REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. AGENCY USE ONLY (*Leave Blank*)	2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
	14 April 2000	FINAL REPORT (07-99 TO 04-00)

4. TITLE AND SUBTITLE
A CRITICAL REVIEW OF THE ARMY MEDICAL BOARD SYSTEM AT MADIGAN ARMY MEDICAL CENTER

5. FUNDING NUMBERS

5. AUTHOR(S)
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MADIGAN ARMY MEDICAL CENTER
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8. PERFORMING RGANIZATION REPORT NUMBER
7b-00

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)
US ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
BLDG 2841 MCCS-HRA US ARMY-BAYLOR PROGRAM IN HCA
3151 SCOTT RD SUITE 1412
FORT SAM HOUSTON, TEXAS 78234-6135

10. SPONSORING/MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION/AVAILABILTY STATEMENT
APPROVED FOR PUBLIC RELEASE; DISTRIBUTION IS UNLIMITED

12b. DISTRIBUTION CODE

13. ABSTRACT (*Maximum 200 words*)

The Army medical system evaluates soldiers through the Physical Disability Evaluation System. This study examines two critical questions using Madigan Army Medical Center (MAMC) as a test site: Where are the inefficiencies in the process, and how can MAMC approach the mission differently to reduce processing times?

Retrospective data, consisting of 200 Medical Evaluation Board (MEB) cases, provided the basis for examining the process. The researcher used stepwise linear regression analysis to determine relationships among variables and the overall process. Comparisons with the Air Force and Navy programs yielded suggestions for improving the program.

The research effort relied upon existing data maintained by MAMC, interviews with various service representatives, and SPSS software for analyzing the data. Results of the research indicate that the average MEB processing time at MAMC is approximately 157 days. This time spans from notification of intent to start a MEB until completion. Two steps in the process consume 92.5% of the time: 1) the delivery of care ($p<0.001$) and 2) preparation of the MEB narrative summary ($p<0.001$). By comparison, the two sister services accomplish the same MEB tasks much quicker. The Air Force performs best, completing MEBs within 21 days on average.

14. SUBJECT TERMS
MEDICAL BOARDS, MEB, PDES, DISABILITY EVALUATION, MHS, USAPDA, ARMY MEDICAL DEPARTMENT, AMEDD, MAMC, PEB

15. NUMBER OF PAGES
85

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
N/A	N/A	N/A	UL

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std. Z39-18
298-102

Running head: Medical Board Processing

U.S. Army-Baylor Graduate Program in Health Care Administration
Graduate Management Project

A Critical Review of the Army Medical Board System at Madigan Army Medical Center

Submitted To The Faculty of
U.S. Army - Baylor University Graduate Program in Health Care Administration
In Partial Fulfillment of the
Requirements for the Degree of
Master of Healthcare Administration
By

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14 April, 2000

ACKNOWLEDGMENTS

I take this opportunity to express my sincere thanks to the many people whose assistance and guidance were invaluable in completing this project.

To my preceptors, Colonel Van Booth and LTC Margaret Rivera, (Deputy Commander for Administration/Chief of Staff, Madigan Army Medical Center (MAMC) and Western Regional Medical Command), for the latitude they extended to me, and their constant encouragement, and guidance.

Additionally, I extend my gratitude to all the members of the Fort Lewis PEB with special recognition to Sonya who provided me with the extensive case data for calendar year 1999.

To my reader: Dr. Dave Mangelsdorff. My thanks for his willingness to take me on just before the culmination of the didactic phase and always offering nothing but continual support during the last two years and his encouragement in my pursuit of excellence in this project.

My thanks to the Madigan Army Medical Center Patient Administration staff. LTC (RET) Dave Smith and 1LT Justin Budd opened their doors and gave me complete access to the necessary information while always taking time to answer my questions. Their entire staff never failed to share their technical assistance in the collection of data used in this project.

Special thanks to Lieutenant Mark Everett, USCG (Administrative Resident, U.S. Army-Baylor University Graduate Program in Health Care Administration), who endured my constant questioning and cynical analysis of the government processes seemingly at odds with our stated objectives. He not only suffered through a year of rotations with me, he shared his love of family and life which meant a great deal during some difficult personal times. LT Everett never failed to offer his encouragement during the last two years.

To Ms. Celia Boyce, (Secretary to the Deputy Commander for Administration, MAMC), for her support, encouragement, and proof-reading skills.

To my patient and lovely wife, Liz, and our fantastic boys, Brandon and Christian; my gratitude for your understanding, support and love.

Finally, to the memory of my loving mother, Marge Paxton. From her instruction I learned love, honesty, integrity, and perspective. Thank you for believing in me, Mom.

ABSTRACT

To support a physically and mentally prepared Army, the Army medical system evaluates soldiers through the Physical Disability Evaluation System. This study examines two critical questions using Madigan Army Medical Center (MAMC) as a test site: Where are the inefficiencies in the process, and how can MAMC approach the mission differently to reduce processing times?

Retrospective data, consisting of 200 Medical Evaluation Board (MEB) cases, provided the basis for examining the process. The researcher used stepwise linear regression analysis to determine relationships among variables and the overall process. This statistical method revealed where the greatest impediments lie for processing cases. Comparisons with the Air Force and Navy programs yielded suggestions for improving the program.

The research effort relied upon existing data maintained by MAMC, interviews with various service representatives, and SPSS software for analyzing the data. Results of the research indicate that the average MEB processing time at MAMC is approximately 157 days. This time spans from notification of intent to start a MEB to completion. Two steps in the process consume 92.5% of the time: 1) the delivery of care ($p<0.001$) and 2) preparation of the MEB narrative summary ($p<0.001$). By comparison, the two sister services accomplish the same MEB tasks much quicker. The Air Force performs best, completing MEBs within 21 days on average.

Study conclusions include considering the Air Force approach and adopting processes as practicable considering mission requirements. Also, findings indicate an error in how the Army counts processing days based on the automated tracking tool used. Modifications to the software, or by-hand calculations, are necessary to accurately report processing times. Finally, the Army should reconsider addressing all of an evaluee's medical complaints rather than simply focusing on conditions considered disqualifying for service.

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INTRODUCTION

Military units today operate in a contingency environment, ready to deploy with little warning, and expected to do so quickly. This environment requires a high state of readiness both in training and personnel status. To illustrate just how busy the military is, consider the following facts presented by the Department of Defense (DOD). Since the end of the Cold War through 1998, the United States' military has deployed forces for 93 major commitments to nearly every corner of the globe. During this timeframe, major deployments increased 300 percent and personnel strength decreased 38 percent. Since 1989 the U.S. defense budget has decreased 31 percent and the Armed Forces operate from 10 percent fewer bases. Specifically, the Army has deactivated eight divisions (Defense*LINK*, 1999). In light of these changes, maximum availability of personnel in operational units is paramount. The Physical Disability Evaluation System (PDES) supports the mission of manning the force, in conjunction with the personnel component, by quickly and accurately processing soldiers (for possible termination of service) with potential disabilities.

Manning the force may be the least appreciated and most frequently misunderstood of the six logistical imperatives embraced by the Army. When leaders consider manning the force, they generally focus on the personnel component providing assignment instructions for replacements. This is obviously important for without people on the battlefield we cannot fight, but the element of manning most often overlooked or taken for granted is the medical component. The medical staff identifies injured or diseased soldiers unlikely to meet minimum Army physical qualification standards and refers them to a medical board. Unit commanders cannot requisition replacement soldiers until the

PDES process is complete. Quite reasonably in time of war, a medical board will not stop the personnel component from assigning replacements for injured soldiers; however, in peacetime that is exactly what happens.

In light of the administrative rules for manning the force in peacetime, the medical role for facilitating the replacement of soldiers is critical for the Armed Forces to continue protecting the innocent and promoting peace around the world. The medical readiness of American soldiers starts well before the issuance of deployment orders, and medical readiness begins with each individual soldier on every military installation. Fort Lewis, Washington is the military installation of concern for this study. The research focuses on only those cases involving individuals on active duty for greater than 30 days, and provides an approach for identifying the statistically significant factors associated with slowing the processing of soldiers through the initial phase of the PDES.

Conditions Which Prompted the Study

The U.S. military is currently operating at a very high operational tempo. Challenges to sustaining readiness rest primarily in three variables: people, equipment, and training. A deficit in any one of the variables degrades readiness. Manpower is the key prerequisite for effective training, and the health care delivery team greatly influences how long a soldier is unavailable to the unit and how long a unit must function with less than optimal personnel resources. The Military Health System (MHS) therefore, is critical to the manning and the readiness of the force.

Supporting the force medically does not relieve the MHS of the tremendous political and economic pressure to reduce inefficiencies in military treatment facilities (MTFs). The source of this pressure is the considerable cost of operating military hospitals.

According to the General Accounting Office (GAO), this cost totaled $15 billion in 1997 and represented 6 percent of the total budget allocated to the DOD (General Accounting Office, 1997). During the same year the Medical Board Working Group, a body established under the guidance of the Assistant Secretary of Defense for Health Affairs (ASD(HA)), concluded that the Army spent $737 thousand a day processing injured soldiers through the PDES (Grubb, 1997). Clearly every effort must be made to identify inefficient processes and procedures as well as recommend solutions in order to speed up the system, therefore resulting in increased soldier availability and decreased costs.

Problem Statement

To assist units in maintaining a high personnel readiness posture, the MHS must ensure that it performs all medical board functions in a timely manner without compromising the quality of care delivered to beneficiaries. In addition to regulatory guidance, the process for delivering quality care must include leadership and training. Persons involved must be prepared to make timely decisions. Those same individuals must understand the impact of their action or inaction on the units awaiting the soldier's final disposition. The problem facing the Army in general, and Madigan Army Medical Center specifically, is identifying where in the initial phase of the PDES opportunities for efficiencies exist in order to improve or restructure the process.

Literature Review

To facilitate a better understanding of the subject, the following literature review addresses the PDES, which is responsible for the program at various levels, and focuses on key elements and governance of the medical board process. Regardless of how well the medical board process is working, it is critical to understand that the Army process

derives from laws and DOD guidance. These documents are referenced throughout this review and are available in their entirety on the Internet.

The Physical Disability Evaluation System. The PDES is comprised of the following basic components: (a) medical evaluation, (b) physical disability evaluation, (c) counseling, and (d) final disposition. The PDES can be complex, but the process basically starts when a physician believes a soldier can no longer meet the retention standards outlined in Standards of Medical Fitness (AR 40-501) and ends when the soldier is retained on active duty or is issued retirement or separation orders by the United States Army Personnel Command (PERSCOM). Before 1980, the counseling phase was not formally recognized. Formal inclusion of counseling in the PDES underlines the importance of ensuring soldiers' rights are protected throughout the PDES process.

Program Responsibilities. Several persons play a role in the PDES, but the overall program responsibility rests with the Under Secretary of Defense for Personnel and Readiness. He delegates program responsibilities to ASD(HA) who is responsible for developing and maintaining a PDES training program. The ASD(HA) also has responsibility for developing policies as well as monitoring the timeliness of the medical component of the PDES, and proposing prospective corrective actions as necessary. The ASD(HA) responsibility to establish minimum standards for MEBs affects this study the most (DODD 1332.18, 1996).

The ASD(HA) delegates responsibility for addressing the issue of medical functions to the service Secretaries. To ensure that every service member is treated fairly and provided with quality health care, each Secretary focuses on compliance with Chapter 61

of Title 10 United States Code (USC), DODD 1332.18 (1996) and instructions and guidance issued under that directive. Each Secretary is responsible for establishing his/her Service's PDES so that it complies with guidance regarding timeliness and uniform application of laws and DOD policy.

While the Secretary of the Army (SA) may delegate PDES functions, the powers and responsibilities of the Secretary remain with the office and is ultimately responsible for oversight and execution of the Army's PDES. Title 10, Chapter 61, § 1201 (1998), clearly outlines his specific powers and responsibilities, such as actual determination of disability. He, or his designated representative, must determine disability based on "accepted medical principles, which indicate the disability is of a permanent nature and stable" (10 USC § 1201, 1998). Additionally, the Secretary must find that the disability is not the result of the member's intentional misconduct or willful neglect, and was not incurred during a period of unauthorized absence. These findings are based on the Line of Duty (LOD) investigation. The SA obviously does not execute these decisions personally; he delegates this authority to the Army agency responsible for receiving Physical Evaluation Board (PEB) findings--the United States Army Physical Disability Agency (USAPDA).

Medical Evaluation Board (MEB). Chapter seven of Medical, Dental, and Veterinary Care (AR 40-3, 1985), details the MEB structure and process. The MEB is an informal proceeding consisting of at least two physicians. During the course of the MEB, the physicians refer to medical fitness standards contained in AR 40-501, chapter three (1998). The regulation lists various medical conditions and physical defects that may render a soldier unfit for military duty. The proceedings, although informal, are required

to be annotated on the Medical Evaluation Board Proceedings worksheet (DA Form 3947). A brief, but complete, clinical history prepared by the attending physician is also required as part of MEB documentation, and is attached to the DA Form 3947. This brief medical history includes commentary on all available prior medical records from the soldiers' entry into the service (AR 40-3, 1985).

The medical evaluation segment of the PDES documents the medical status and duty limitations of the service member referred to the PDES. The type of medical evaluation required is not specified; however, the guidance does require the physical examination to document the full clinical information of the service member's medical conditions. Additionally, a note must be made for each condition indicating if it is a cause for referral into the PDES. The clinical information must include "a medical history, appropriate physical examination, medical tests and results, all consultations, diagnoses, treatment and prognosis" (DODI 1332.38, 1996, E3.P1.2.3). To ensure standardization, physicians who prepare MEBs are encouraged to use the Department of Veterans Affairs' Physician's Guide for Disability Evaluation Examinations to indicate the nature and degree of severity of the soldier's condition (AR 635-40, 1990). The DOD sets an allowable time for processing MEB cases at 30 days. Before submitting the MEB packet to the PEB, the board physician(s) must complete a narrative summary (NARSUM) of the case. In reaching a conclusion, the physician(s) must consider all medical examination evidence, medical history, results of x-rays and laboratory tests, reports of consultations, and responses to therapy. The MEB processing time spans from the date of report dictation to the PEB date of receipt (DODI 1332.38,1996).

As outlined in DODI 1332.38 (1996), MEB packets forwarded to the PEB shall include the following information:

1. Member's name, rank, grade, and social security number;
2. Specialty of the signatory physicians;
3. Clinical department or service;
4. Medical treatment facility and its location;
5. Date MEB was conducted;
6. Copy of the Line of Duty determination;
7. Letter from the soldier's commander describing how the member's medical condition impacts job performance and deployability status;
8. Military history to include date of first and most recent entry into the service; estimated termination of service; administrative actions ongoing, pending, or completed;
9. Chief complaint, preferably stated in the soldier's own words;
10. Social information including living arrangements, marital status, leisure activity, acquaintances, substance use or abuse, police encounters/record;
11. Functional status of the soldier;
12. Statement regarding prognosis for functional prognosis post-treatment period;
13. Stability of current clinical condition;
14. Statement of compliance with treatment recommendations and reasonableness of any refusal of recommended treatment procedures;
15. Requirement for monitoring including frequency of indicated treatment and/or therapy visits and associated operational assignment limitations; and

16. Official documents identifying next of kin if service member is legally incompetent.

According to DODD 1332.18 (1996), the sole standard for making determinations of unfitness due to physical disability is based on ability to perform the duties of the service member's office, grade, or rank because of disease or injury. The MEB process (Figure 1) is the vehicle for determining a soldier's fitness for duty.

Physical Evaluation Board Liaison Officer (PEBLO). The PEBLO is an important person in the PDES. This person, residing in the local MTF, serves as a counselor to the soldier as well as the physician, acts as a case manager, and is a liaison between the MTF and PEB. Potentially the most critical service a PEBLO provides is ensuring soldiers receive counseling regarding what to expect throughout the MEB process. Additional PEBLO services offered before a PEB include educating the soldier on the sequence of events of the PDES, and providing advice on statutory and regulatory rights. After the informal PEB process is complete, the PEBLO again counsels the soldier. Some of the salient topics covered in this counseling include:

1. Recourse for rebuttals;
2. Estimated retired or severance pay based upon the PEB's findings and recommendations;
3. Probable retirement grade;
4. Potential benefits; and
5. Where to find a defense counselor if the soldier wants to request a formal PEB (AR 635-40, 1990).

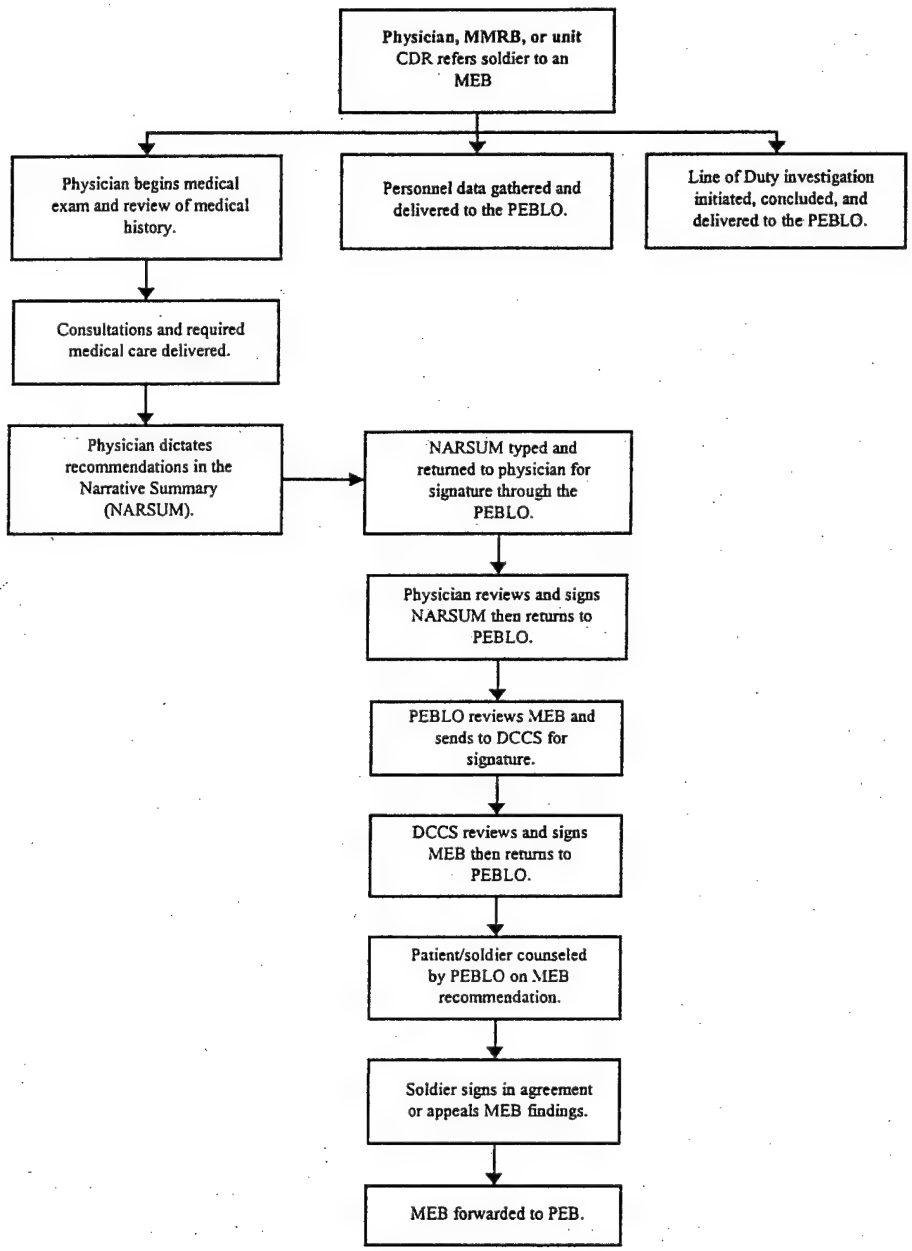

Figure 1. The Army MEB Process (AR 40-3, 1985)

Prior to the PEB, the PEBLO performs another role previously mentioned--case manager. In this role, the PEBLO follows the soldier's progress through the MEB process and records significant dates and events in the Medical Evaluation Board Internal

Tracking Tool (MEBITT). If a delay becomes apparent, the PEBLO can energize the system by making calls and inquiring why progress has slowed or halted. After the physician(s) sign the MEB NARSUM, the PEBLO receives the packet and reviews it for completeness before sending the documentation to the Deputy Commander for Clinical Services (DCCS) for review and approval. Once the DCCS approves the MEB documentation, the PEBLO performs his liaison function and delivers the MEB packet to the PEB.

Physical Evaluation Board. The PEB is the responsible body for conducting the physical disability evaluation. Members are assigned to the board on a permanent basis, thus ensuring that other duties or roles do not distract them. This is a formal body, consisting of three members: President, personnel management officer, and medical officer. The president and personnel officer are commissioned officers. The medical member may be an officer or Department of the Army (DA) civilian physician with U.S. Army Medical Corps experience. The caveat to the medical member's presence on the board is that he must not have served in any capacity with the MEB referring the soldier to the PEB (AR 635-40, 1990).

The PEB determines fitness for duty. If the soldier is entitled to benefits, the PEB assigns a percentage rating for each compensable disability. This rating equates to a percentage of the soldier's base pay that he will receive when separated or retired. The percentages assigned to disabling conditions are computed using the Veterans Administration Schedule for Rating Disabilities (VASRD). Determining whether a

soldier is entitled to benefits greatly depends on the LOD investigation.[1] If the LOD determines that the disability resulted incident to service, then the soldier is entitled to benefits. As part of the process, the PEB must also determine if the disability is permanent or likely to change in the next five years. This decision could lead either to direct retirement or placement on the temporarily retired disability list (TDRL)[2] (AR 635-40, 1990).

The PEB expects to receive a host of administrative data in addition to the medical information referenced previously in the MEB section. Also included in the MEB packet is a statement from the custodian of the soldier's personnel records identifying any retirement processing actions pending, expiration of term of service (with or without bar to reenlistment), whether involuntary release from active duty due to DA board action is pending, adverse personnel actions, and if the soldier is facing qualitative management denial[3] for reenlistment (AR 635-40, 1990). The PEB also considers the soldier's personnel qualification record.

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[1] A Line of Duty investigation simply addresses whether a disability occurred concurrently with military duties. The definition of concurrent to duty includes approved leave time.

[2] Soldiers may remain temporarily retired for up to five years. Within that period, they are required to have periodic physical examinations every 12-18 months. If a soldier does not progress to the point he can be removed from the TDRL by year five, then he is permanently retired. If he recovers to the point that his injury is no longer 30 percent compensable (the standard for retired status), he is brought back on active duty and separated from the service.

[3] Qualitative management denial is an action taken in accordance with the Qualitative Management Program. This program may deny further service to non-progressive or non-productive soldiers. It is used to eliminate soldiers who do not meet performance conduct and attitude standards, and do not have the potential for advancement.

Initially the PEB reviews the information presented in the MEB packet and makes a recommendation. This is the informal PEB sequence and the soldier does not personally appear before the board. Upon receiving the informal PEB results, the service member either agrees or disagrees with the findings. The PEBLO documents the soldier's response in the counseling record. If the service member does not agree with the initial findings, then he may request a formal PEB hearing in accordance with Title 10 USC § 1214. During the PEB process a soldier has the right to legal counsel. Legal representation is offered for the purpose of providing a full and fair hearing as outlined in Title 10 (10 USC § 1214, 1999). The soldier may appear before the board in person, via video teleconference, or send a designated representative (DODI 1332.38, 1996). The DOD guidance found in the Physical Disability Evaluation instruction (DODI 1332.38, 1996) states that the PEB process should not exceed 40 days from date of receipt of the MEB packet until determination of the final reviewing authority. For the Army, the reviewing authority is the Deputy Chief of Staff for Personnel (DCSPER) (DODI 1332.38, 1996).

Prerequisites for Disability Processing. Paragraph (c) of § 1201 (10 USC § 1201,1998) clearly identifies who is eligible for disability considerations under chapter 61 - Retirement or Separation for Physical Disability. Specifically eligible are those service members meeting one of the following stipulations:

1. Members of a regular component of the Armed Forces entitled to basic pay;
2. Reserve forces personnel entitled to basic pay as a result of being called or ordered to active duty (other than for training under Title 10, § 10148(a)) for a period of more than 30 days; or

3. Any other member of the armed forces who is on active duty but is not entitled to basic pay by reason of § 502(b) of Title 37 due to an authorized absence for the purpose of participating in an educational program, or for an emergency situation (Cornell University, 1999).

Legal Provisions. Title 10, USC governs the operation of the Armed Forces. This important document became effective August 10, 1956 and is the foundation of military operating management today (Cornell University, 1999). Chapter 61 of Title 10, USC (1999), provides the legal structure for handling physical disability separation cases. The intent of chapter 61 is to ensure service members receive due process just as any American citizen would. The DOD builds upon chapter 61 instructions to formulate instructions and directives (DODI and DODD) to the services regarding implementation of the PDES.

Building on Title 10, DOD policy advises that the PDES will be the vehicle for implementing retirement or separation due to physical disability (DODD 1332.18, 1996). Continuing one step further, DODI 1332.38 (1996) specifically outlines the operational standards for the PDES. A specific concern for processing soldier disability cases includes a determination as to the source of the injury and the conditions surrounding the incident(s) resulting in the injury(s). On this point, 10 USC § 1207 (1998) stipulates that only those injuries incurred while in the line of duty are compensable.

Related Studies. There are very few published or unpublished papers on the subject of military medical boards. In fact, in conducting a literature search, only one relevant study surfaced. The paper is an unpublished thesis by Coquilla (1990) titled "A Study to

Determine Factors Contributing to the Medical Evaluation Board Processing Time at the Joint Military Medical Command - Brooke Army Medical Center (BAMC)."

Coquilla's (1990) study focused on identifying the various segments of the MEB and drew data from PEBLO worksheets that allowed the researcher to create time segments that became the operational variables. A review of the study indicates little has changed regarding the basic steps for processing a MEB. This is due to the lack of changes in statutory or DOD guidance for the process.

Coquilla's lynchpin for determining if any of the study's independent variables truly influence the dependent variable of time is statistical analysis. The researcher uses Pearson's Correlation Coefficient and a *t*-test for measuring statistical significance and relationships among variables in her findings. The approach determines relationships among variables as well as the degree to which they are related. She concludes that processing times of the MEB are statistically affected by the PEBLO and attending physician time segments[4] (Coquilla, 1990). The PEBLO phase includes collecting administrative and personnel documents as well as notifying and counseling soldiers on the MEB findings. The physician phase includes the narrative summary as well as examinations.

In her findings, Coquilla (1990) notes that the 30-day period allowed from the NARSUM to delivery to the PEB is insufficient and that BAMC averages 59.6 days to complete the process. She also notes that a 1988 Army Audit Agency (AAA) report

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[4] Coquilla's study occurred before the MOS Medical Review Board (MMRB) came into existence. Her reference to the attending physician time segments is equivalent to this study's physician time in the MEB segment.

indicates the average MTF processing time is 55 days. The AAA report goes on to recommend, and Coquilla agrees, that the MEB process should be broken down into manageable phases and tracked accordingly. This approach would allow accurate analysis of where an organization needs to direct attention in order to resolve processing delays. The office held accountable for the MEB is the Patient Administration Division (PAD). Coquilla's study clearly supports that many forces outside of the PAD affect the processing time of the MEB.

The one notable limitation of Coquilla's study is that it may not apply universally to all MTFs. Coquilla completed her study using an Army Medical Center (MEDCEN). Medical Centers have more resources and more specialties compared to smaller community-size hospitals (referred to as medical department activities), therefore making direct comparisons to any facility other than an Army MEDCEN questionable.

Purpose

The purpose of this research effort is to evaluate the MEB process at MAMC in order to identify opportunities for improvement. The intent is to decrease the total time soldiers spend in the MEB phase and, by extension, the PDES overall. Restated, the study focuses on identifying those segments of the MEB that significantly contribute the most time to processing soldiers and then recommending improvements. The study has one basic supporting objective for accomplishing this task.

Supporting Objective. The specific requirements necessary for analyzing the MEB process are:

1. Defining the specific segments of the MAMC MEB,
2. Determining the total average processing time of the MAMC MEB, and

3. Determining which segments contribute significantly to delays in processing soldiers through the PDES medical evaluation.

Subordinate Requirement 1. To accomplish the supporting objective, the first subordinate requirement is to define each segment of the MEB. All of the required MEB steps are reviewed and categorized using a chronological grouping of events. This approach provides the framework for establishing specific segments of the processes.

Subordinate Requirements 2 and 3. These two requirements, determining the average processing times for each segment and determining if any of the segments are significantly responsible for the duration of the process, are achieved simultaneously through statistical analysis. Descriptive statistics present an indication of what factors may influence the process and are generated as part of the statistical analysis using SPSS 9.0 software.

To determine if any one phase is significantly responsible for lengthening the process, the null hypothesis (H_O) for requirement 3 is stated as: total MEB processing times (Y_1) are independent (not influenced by) of the specific processing segments ($T_1 \ldots T_5$); or [H_O: $Y_1 \neq f(T_1 \ldots T_5)$]. Thus, the alternate hypothesis (H_A) is stated as: total MEB processing times (Y_1) are dependent (influenced by) of specific processing segments ($T_1 \ldots T_5$); or [H_A: $Y_1 = f(T_1 \ldots T_5)$].

METHODS AND PROCEDURES

The primary focus of this research effort is to identify where unnecessary time delays exist in the current Army process and compare these procedural delays with sister service processes to determine if there is a better way to execute the PDES mission. This research uses data obtained from PEBLOs at MAMC and administrative staff at the Fort Lewis PEB. Interviews with key personnel at MAMC, Fort Lewis PEB, Wilford Hall Medical Center, McChord AFB health clinic, the USAPDA, and the Navy Council of Personnel Boards Office provides the framework for comparing service processes. Interviews with the MAMC DCCS identify critical issues for the Army and offer potential methods for improving the existing process from the viewpoint of the medical approving authority.

Descriptive data drawn from Army MEB case records include:

1. ID number (used to mask the name and social security number);
2. Age;
3. Gender;
4. Branch of military service;
5. Rank;
6. Years of active service;
7. Primary MOS, and
8. Primary diagnosis.

Descriptive statistics for MEB processing data is also included to determine if any other issues contribute to lengthy processing times. Appendix A displays the raw data used for

the study. Specific statistical tools and methods employed are discussed in the Method Section.

Ethical Considerations

Ethical issues associated with this research effort include access to personal information such as names, social security numbers, and medical diagnoses. All materials and documents under review containing personal information have been maintained in a secure location. Disclosure of identities has not and will not be made, nor is identifiable patient information used in the study. All cases are assigned an identification number, rendering the patient anonymous. Any publication of this study will not disclose individual patient identification.

Data Sources

Data sources for this study include the MAMC PEBLO databases and the Fort Lewis PEB database. The MAMC staff uses a software package called Medical Evaluation Board Internal Tracking Tool (MEBITT) to maintain its data. The PEB uses a database software package developed specifically for PEB use by the USAPDA. All data used is retrospective and categorical.

Validity and Reliability

Reliability is a contributor to validity and is a necessary, but not sufficient, condition for validity (Cooper and Emory, 1995). The data for this case study is made available by the independently managed sources outlined above. The MAMC staff maintains its information on a standard platform, but actual computation of the processing days is suspect. Because there are no mechanisms to ensure accuracy, data validity and reliability are questionable.

Reliability ensures the research effort has consistency and is free of random or unstable error (Cooper and Emory, 1995). The steps to establish reliability include: use of standardized database sources; use of the same individual to collect the data from the sources; and use of a second investigator to randomly check the accuracy of transferring raw data to the software programs.

Physical Evaluation Board Liaison Officer data is maintained on a standardized database. The only person collecting the data is the PEBLO and, theoretically, only one PEBLO processes a case. Different individuals, however, may access the software simultaneously and when this occurs, the record is duplicated creating another file with the same demographic data, but with incomplete annotations. Reliability, and validity of the data, is likely compromised when this occurs. This necessitates numerous reconciliations. A second investigator is not employed to check data accuracy; however, each PEBLO must verify the data several times before transferring the case to the PEB, ideally correcting any of the reliability errors noted.

Unlike questions regarding reliability, the researcher finds the data completely valid. The information contained in the MEB records include all the dates necessary to accurately measure the time a soldier is subject to the first phase of the PDES. From the records the researcher is able to measure exactly what was intended. External validity of this study is not so absolute. The construct may be exported to all MTFs, but comparing the existing Army implementation of MEBs at a small facility as opposed to a large medical center will generally not work. This assertion is made primarily on available specialty services. The presence of specialty services is shown to increase MEB processing times (R. Anderson, personal communication, September 9, 1999).

Regardless of where this study's construct is reproduced, a causal relationship will be present.

Assumptions

"It is not within the mission of the Military Departments to retain members on active duty …to provide prolonged, definitive medical care when it is unlikely the member will return to full military duty" (DODI 1332.38, 1996, E3.P1.6.1). The DOD guidance is to refer members into the PDES as soon as the physician believes the soldier will be unable to return to full duty and optimal medical treatment benefit has been attained. Four important assumptions support the research:

1. Data reliability for this study is suspect; therefore, an important assumption is that at some point in the data transfer process a training element is introduced to ensure that input is consistent and the personnel inputting the data receive training.
2. A statistically appropriate sample size based on variance from the mean and a standard deviation of 30 days (as determined by the researcher) with a 95% confidence interval is 35 cases.
3. The working assumption is that the DOD is not likely to direct changes for processing MEB cases.
4. There are ways to improve the Army process and still remain compliant with statutory and regulatory guidance.

Method

This research assesses the MEB function and discusses the impact when viewed as a component of the PDES. The emphasis is on determining if the MEB phase is meeting

the established objectives for processing time and outcomes. Data is analyzed using Pearson's Correlation Coefficient. This statistical tool measures the strength of the relationship between two or more variables. For this study, Pearson's Correlation Coefficient measures how significantly the different independent variables, or time segments, affect the overall dependent variable of medical board processing times. To test the statistical significance of the hypotheses, a two-tailed *t*-test is used with a significance level (α) of .05. Stepwise linear regression further discerns which of the variables influence the model the most. By analyzing each variable one at a time, the specific impact is measured, thus indicating which variables influence processing times the most.

Due to MEB process variance from service to service, only average MAMC processing times are compared to the Air Force and Navy. The intent is to see how MAMC compares to the other Services and address whether MAMC could adopt the Navy or Air Force approach to improve any deficiencies noted. Comparing Service specific systems side by side will illuminate differences. Where differences exist, analysis must detail whether or not the Service is following statutory and regulatory guidance. Statutory compliance is an absolute requirement for any recommended change. All services have the same statutory and DOD guidance, but the fact of the matter is that the guidance is not so prescriptive as to preclude varying interpretations.

Operational Definition of Variables

The focus of this study is time, so all variables will be annotated using the following convention: T_1, T_2, T_3 and so on as necessary. Operationalizing the variables also accomplishes requirement 1, which is to identify specific segments of the MEB process.

Table 1 depicts the operational definitions for the variables as time segments and the corresponding variable labels.

Table 1.

Operational Definition of Variables

Variable	Definition
T_1	MEB phase: begins when the MAMC PAD office is notified that a physician or MMRB[5] is recommending a soldier for a MEB and ends when the medical board NARSUM is dictated.
T_2	NARSUM preparation phase: the time between dictation and the date when the physician signs the completed NARSUM.
T_3	PEBLO phase: the MEB is received from the physician signed and delivered to the DCCS for approval and signature.
T_4	Soldier phase: begins when the PEBLO receives the completed MEB packet from the DCCS and ends when the soldier/patient signs the MEB.
T_5	MEB Completion phase: this is the period covered from the soldier signature until the MEB packet is forwarded to the PEB.
T_6	Total MEB processing time: this covers T_1 through T_5.

[5] A board established to review soldiers' conditions and military histories. Commanders submit letters addressing soldier performance and how the physical profile does or does not inhibit duty performance. The board process culminates with one of the following recommendations: retain the soldier in his current MOS; retain the soldier for a probationary period; reclassify the soldier; or refer the soldier to the PDES.

THE RESULTS

Application and Results

The investigator analyzed MAMC's MEB process using 200 cases (Appendix A) from calendar year 1999. Comparison of the PAD MEBBITT data and the PEB data provided an accuracy check required due to the question presented previously regarding data reliability. The PEB lists the date for each of the case segments, therefore, verifying accuracy of the MEBITT data.

Descriptive Statistics. The descriptive statistics indicate that the MAMC MEB process is extremely lengthy and that two stages account for a majority of the processing time. These impressions are pursued in detail as the actual statistical analysis is conducted. Descriptive statistics often raise questions as to various relationships among variables. The investigator queried age, time in service, rank, and gender in addition to the dependent and independent variables to discover anything noteworthy. These descriptive results (Table 2, Table 3, and Figure 2) indicate nothing warranting further analysis. Of note, however, is the percentage of cases by rank (Figure 2). There is no significant relationship between rank and processing time, but the graph clearly shows what ranks experience the largest number of disqualifying injuries and diseases at Fort Lewis. Cases by rank, as well as by gender (Table 3), proportionally reflect the Army population as a whole (*Defense*Link, 2000).

Table 2.

MEB Descriptive Statistics

	N	Minimum (days)	Maximum (days)	Mean	Std. Deviation
T6: Total time for the MEB	200	7	616	157.11	89.38
age	195	18	49	28.88	7.32
Time in Service	194	.75	25.00	7.6469	5.8585
T1: MEB Phase/optimal care delivered	200	1.00	554.00	83.9000	71.2258
T2: NARSUM - dictation to signature	200	.50	271.00	53.1475	38.7818
T3: PEBLO Phase	200	.30	81.00	3.6245	8.0566
T4: Soldier Phase	200	.30	121.00	7.9170	13.9685
T5: Final MEB Phase	200	.30	99.00	8.5195	15.3007
Valid N (listwise)	192				

Table 3.

MEB Cases by Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	160	80.0	80.0	80.0
	Female	40	20.0	20.0	100.0
	Total	200	100.0	100.0	

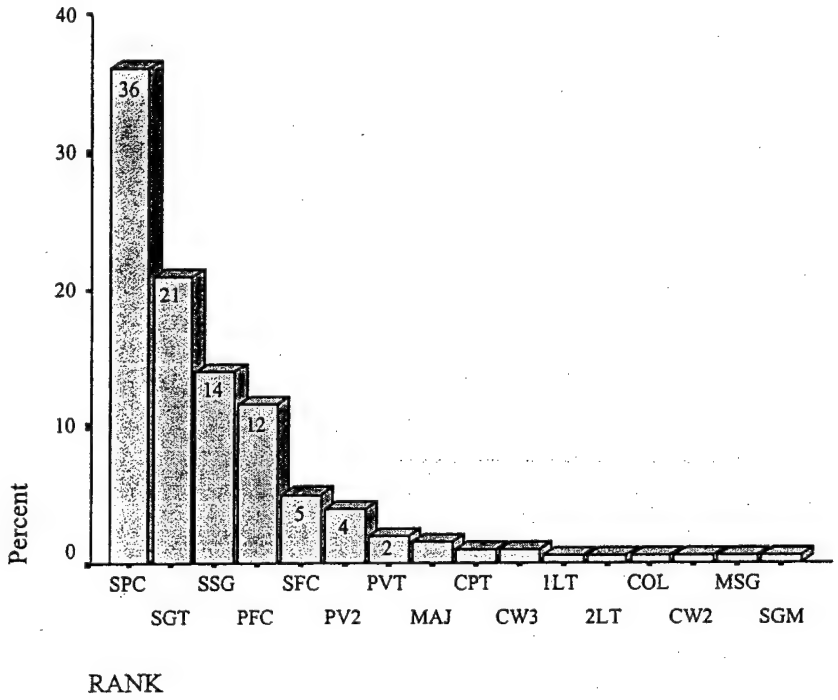

Figure 2. Cases by Rank

Correlation of Variables. The Coefficient of Correlation, also referred to as Pearson's *r*, measures the closeness or interdependence of the relationship between *x* and *y*. The value of Pearson's *r* is on a scale between -1.00 and +1.00. "When Pearson's *r* is zero, there is no correlation, and when Pearson's *r* equals -1.00 or +1.00, there is perfect correlation. Thus, the closer the observed value of Pearson's *r* is to its limit of ± 1.00, the stronger the correlation" (Sanders, 1995, p. 527). Strong correlation, positive or negative, may indicate a causal, complimentary, parallel, or reciprocal relationship. Table 3-4 displays results of the assessment of correlation (Pearson's *r*) of the independent variables ($T_1 \ldots T_5$) to the dependent variable of total MEB processing time (T_6). As viewed in Table 4, all of the independent variables have a p-value of .05 or less for a two-tailed *t*-test. This indicates that a relationship exists; however, to what degree each

variable contributes is not clear. Before drawing any conclusions, a hypothesis test is necessary. This study uses the six step process described by Sanders (1995).

Table 4.

Correlation Matrix for MEB Variables

		T6: Total time for the MEB	T1: MEB Phase/optimal care delivered	T2: NARSUM - dictation to signature	T3: PEBLO Phase	T4: Soldier Phase	T5: Final MEB Phase	Age	Time in Service
T6: Total time for the MEB	Pearson Correlation	1.000	.879**	.485**	.200**	.142*	.285**	.241**	.151*
	Sig. (2-tailed)	.	.000	.000	.005	.046	.000	.001	.036
	N	200	200	200	200	200	200	195	194
T1: MEB Phase/optimal care delivered	Pearson Correlation	.879**	1.000	.110	.068	.010	.157*	.236**	.127
	Sig. (2-tailed)	.000	.	.119	.341	.894	.026	.001	.077
	N	200	200	200	200	200	200	195	194
T2: NARSUM - dictation to signature	Pearson Correlation	.485**	.110	1.000	.075	-.135	-.134	.130	.104
	Sig. (2-tailed)	.000	.119	.	.288	.058	.058	.069	.148
	N	200	200	200	200	200	200	195	194
T3: PEBLO Phase	Pearson Correlation	.200**	.068	.075	1.000	-.009	.143*	-.006	.000
	Sig. (2-tailed)	.005	.341	.288	.	.905	.044	.938	1.000
	N	200	200	200	200	200	200	195	194
T4: Soldier Phase	Pearson Correlation	.142*	.010	-.135	-.009	1.000	.215**	-.017	.008
	Sig. (2-tailed)	.046	.894	.058	.905	.	.002	.809	.907
	N	200	200	200	200	200	200	195	194
T5: Final MEB Phase	Pearson Correlation	.285**	.157*	-.134	.143*	.215**	1.000	-.007	.025
	Sig. (2-tailed)	.000	.026	.058	.044	.002	.	.918	.732
	N	200	200	200	200	200	200	195	194
Age	Pearson Correlation	.241**	.236**	.130	-.006	-.017	-.007	1.000	.825**
	Sig. (2-tailed)	.001	.001	.069	.938	.809	.918	.	.000
	N	195	195	195	195	195	195	195	192
Time in Service	Pearson Correlation	.151*	.127	.104	.000	.008	.025	.825**	1.000
	Sig. (2-tailed)	.036	.077	.148	1.000	.907	.732	.000	.
	N	194	194	194	194	194	194	192	194

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Hypothesis Test.

1. Formulate the Null and Alternate Hypotheses:

   H_O: $Y_1 \neq f\ (T_1 \ldots T_5)$

   H_A: $Y_1 = f\ (T_1 \ldots T_5)$

2. Select the level of Significance: $\alpha = .05$.

3. Determine the Test Distribution to Use. The test used is the t-distribution.

4. Define the Rejection or Critical Regions. The Rejection Region is determined using the p-value. In Table 6, the p-value is identified in the right hand column under significance.

5. State the Decision Rule. If the p-value is less than the α-value, then reject the null hypothesis (H_O). If the p-value is greater than the α value, accept the alternate hypothesis (H_A) and fail to reject the null hypothesis (H_O).

6. Make the Statistical Decision. Since the p-value (.000) is less than the α value, we reject H_O which states total MEB processing times (Y_1) are independent (not influenced by) of the specific processing segments ($T_1 \ldots T_5$). Thus, the H_A is accepted: total MEB processing times (Y_1) are dependent (influenced by) of specific processing segments ($T_1 \ldots T_5$).

DISCUSSION

Interpreting the Model

A simple linear regression model indicates each independent variable is highly significant. This is not surprising considering all of the independent variables contribute to the overall processing time of MEB cases. Because all of the independent variables are statistically significant, a stepwise linear regression analysis is used to determine which variables best explain what is happening in the model.

Stepwise linear regression assesses the influence of each time segment on the total processing time one independent variable at a time, thus identifying which are the most influential. The process adds one variable at a time and evaluates the initial model regarding the change in significance and R Square[6] values. It is already known that all of the independent variables are significant, so a cut-off methodology is necessary.

For this study, when the R Square change value is less than .10, the last independent variable added will act as the cut-off point for determining which of the independent variables influence the dependent variable most. The researcher arrived at the .10 value based on doubling the significance level of .05. The decision process is not based on any known literature and may therefore be viewed as arbitrary. Table 5 summarizes the results of the stepwise regression model. The stepwise process creates a new model with each variable considered (Table 6). Table 5 also indicates from model 1 to model 2 the R Square value has a change of .152, and from model 2 to model 3 the R Square value has a change of .045. Based on the decision rule outlined above, the researcher draws the cut-

[6] The coefficient of determination is noted by the symbol r^2 and is a measure of the portion of the total variance in the *y* variable that is explained or accounted for by the introduction of the *x* variable.

off line below model 2. Interpretation of these results is that the most significant independent variables influencing the dependent variable are T_1 and T_2 respectively. Model 2 has an R Square value of .925, thus indicating that 92.5% of the variance in the model is explained by the independent variables T_1 and T_2. Generally, in statistical terms, an R Square value greater than .7 represents a strong model.

Table 5.

Stepwise Linear Regression Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.879[a]	.773	.772	42.66	.773	675.381	1	198	.000	
2	.962[b]	.925	.925	24.54	.152	401.392	1	197	.000	
3	.985[c]	.970	.969	15.62	.045	290.276	1	196	.000	
4	.996[d]	.992	.992	8.01	.022	550.447	1	195	.000	
5	1.000[e]	1.000	1.000	.00	.008	.	1	194	.	1.668

a. Predictors: (Constant), T1: MEB Phase/optimal care delivered

b. Predictors: (Constant), T1: MEB Phase/optimal care delivered, T2: NARSUM - dictation to signature

c. Predictors: (Constant), T1: MEB Phase/optimal care delivered, T2: NARSUM - dictation to signature, T5: Final MEB Phase

d. Predictors: (Constant), T1: MEB Phase/optimal care delivered, T2: NARSUM - dictation to signature, T5: Final MEB Phase , T4: Soldier Phase

e. Predictors: (Constant), T1: MEB Phase/optimal care delivered, T2: NARSUM - dictation to signature, T5: Final MEB Phase , T4: Soldier Phase, T3: PEBLO Phase

Table 6.

Coefficients for Stepwise Linear Regression Model

Model		Unstandardized Coefficients		Standardized Coefficients			95% Confidence Interval for B	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound
1	(Constant)	64.525	4.668		13.822	.000	55.319	73.731
	T1: MEB Phase/optimal care delivered	1.103	.042	.879	25.988	.000	1.020	1.187
	T2: NARSUM - dictation to signature							
	T5: Final MEB Phase							
	T4: Soldier Phase							
	T3: PEBLO Phase							
2	(Constant)	21.030	3.453		6.090	.000	14.220	27.840
	T1: MEB Phase/optimal care delivered	1.049	.025	.836	42.689	.000	1.001	1.098
	T2: NARSUM - dictation to signature	.904	.045	.392	20.035	.000	.815	.993
	T5: Final MEB Phase							
	T4: Soldier Phase							
	T3: PEBLO Phase							
3	(Constant)	10.165	2.289		4.442	.000	5.652	14.679
	T1: MEB Phase/optimal care delivered	1.002	.016	.798	63.055	.000	.970	1.033
	T2: NARSUM - dictation to signature	.981	.029	.426	33.732	.000	.924	1.038
	T5: Final MEB Phase	1.264	.074	.216	17.037	.000	1.117	1.410
	T4: Soldier Phase							
	T3: PEBLO Phase							
4	(Constant)	1.767	1.227		1.440	.151	-.653	4.186
	T1: MEB Phase/optimal care delivered	1.004	.008	.800	123.215	.000	.988	1.020
	T2: NARSUM - dictation to signature	1.018	.015	.442	67.913	.000	.989	1.048
	T5: Final MEB Phase	1.082	.039	.185	27.880	.000	1.006	1.159
	T4: Soldier Phase	.982	.042	.154	23.462	.000	.900	1.065
	T3: PEBLO Phase							
5	(Constant)	-1.996E-14	.000		.	.	.000	.000
	T1: MEB Phase/optimal care delivered	1.000	.000	.797	.	.	1.000	1.000
	T2: NARSUM - dictation to signature	1.000	.000	.434	.	.	1.000	1.000
	T5: Final MEB Phase	1.000	.000	.171	.	.	1.000	1.000
	T4: Soldier Phase	1.000	.000	.156	.	.	1.000	1.000
	T3: PEBLO Phase	1.000	.000	.090	.	.	1.000	1.000

Issues

At this point, the model appears strong and conclusive -- MAMC expends greater than 90% of the MEB process administering care and completing documentation of that care. In conducting further analysis trying to understand why the process seems so inefficient, the investigator interviewed Justin Budd (personal communication, November 17, 1999), the administrator of MAMC's MEB process. He has program oversight responsibilities as well as supervisory responsibilities of the PEBLOs. His insights indicated several issues to evaluate before passing judgement on MAMC's process. These are discussed here to illustrate the concerns that must be addressed to improve the process for MAMC.

Overall Process. Madigan Army Medical Center's approach to the MEB process reflects an Army process that is questionable. Physicians conducting an MEB interview ask patients to list all of their medical complaints rather than simply addressing the board-presenting injury. The interpretation of such practice is that MAMC, and the Army Medical Department as a whole, feels it is providing maximum care for soldiers. The reality is that many of the complaints do not render the soldier unfit for duty and that is precisely the purpose of the MEB -- to medically review conditions rendering soldiers unfit. The PEB only reviews injuries or diseases that fit this description and ignores the rest (R. Anderson, personal communication, September 9, 1999).

Evaluating secondary complaints simply adds to the duration of the MEB. In medical centers, more so than smaller hospitals, physician training fuels this phenomenon. An interesting medical case presents opportunities to learn. The training is legitimate, but at what expense is it acceptable? When specialists are not available, cases

generally only address the presenting disqualifying condition and therefore are completed more quickly. Data from the Fort Lewis PEB supports this position (R. Anderson, personal communication, September 9, 1999). Processing times for the MTFs serviced by the Fort Lewis PEB indicate that smaller hospitals either meet the 30-day suspense or come much closer than the larger facilities.

Many medical boards contain more than one disqualifying injury or disease; therefore requiring medical (specialty) consults. These consults can slow the processing significantly. One way to decrease the impact of consults is to assign medical board consults a priority. Madigan Army Medical Center, in an attempt to decrease processing times, recently did just that -- began assigning MEB cases priority for appointments. Although this attempts to speed the overall process, the question of treating "unfit" conditions is still not addressed.

The difficulty of obtaining an appointment seems to stem from the implementation of managed care. Managed care practices have seemingly blurred the purpose of military health care with respect to who is the priority. The primary customer is the active duty soldier, not the family member or retiree. The TRICARE access standard for routine care is 30 days, and it often takes between two or three weeks before a patient can get in for an appointment. These days directly influence the duration of a MEB case. Without compromising access standards or imploding the Graduate Medical Education program, MEB patients should be recognized and given consideration.

Madigan Army Medical Center recognizes a specific dynamic in the current process that could offer a potential time saving opportunity. When physicians issue permanent

profiles with the identifiers P-3 or P-4[7], the soldier's unit must initiate a MMRB to determine if the soldier should be referred to a MEB (AR 600-60, 1985). Greater than 90% of the cases are referred to a MEB. Rather than waiting for the action to occur (generally 45 days after the profile issuance), MAMC could initiate the MEB requirements and wait for the MMRB referral before continuing (J. Gilman, personal communication, February 10, 2000). If the MMRB does not refer the case to the MEB, then the actions are terminated. This may cause some extra work by the MAMC staff, but historically this work would save nearly one third of the current processing time.

Data Quality. The MEBITT data tracking tool used by MAMC staff does not allow for more than one entry regarding NARSUM dates. This is relevant if a case has any addendum to include, and many at MAMC do because of the numerous medical complaints listed by patients. The time calculated by MEBITT recognizes only the primary NARSUM when, in reality, the computation of dates should begin after the NARSUM or last addendum is completed. For MAMC, this has generated processing times exceeding 157 days. The reality is that, by the DOD standard, MAMC is performing much better -- closer to 100 days.

One statistically significant independent variable contributing to total processing time is the preparation of the NARSUM. The physician dictates the record and an administrative person types it and returns it for signature. The MEBITT records indicate an average turnaround time for a NARSUM is a staggering 56 days. After discussing this

[7] The P-3 and P-4 profiles are categories of permanent physical restriction for soldiers. These two profiles generally restrict a soldier's ability to perform MOS duties beyond a garrison environment. This renders the soldiers unable to perform duties in a world-wide field setting as required by DA PAM 611-21 (1999).

with Justin Budd (personal communication, November 17, 1999) the investigator learned that this time is misrepresented due to the single entry on the MEBITT form for the NARSUM. The 56 days represents the time from the first NARSUM dictation until the final addendum is returned to the physician for signature. During the same conversation Justin Budd commented that the actual turnaround time is less than a week.

Customer Focus. To the true customers, the soldier and his unit, the total processing time of 157 days is the most important indicator of service. This period represents the inability of the unit to replace the injured soldier and degrades unit readiness. Before the MEB packet is forwarded to the PEB, the unit must assist in completing several requirements. Non-medical requirements routinely hold up processing cases. A specific contributing factor to increased processing time is the collection of administrative data by the unit. To serve the soldier and the unit concurrently, the unit command must understand the process and that requires education. Currently little effort is made to explain the entire process to unit commanders.

Education. A significant partner with the MTF in completing a MEB packet is the unit chain-of-command. These persons obtain personnel data, statements from personnel records custodians, and write command recommendations. Nearly every company commander on Fort Lewis is guilty of not understanding what is required of them to complete a MEB packet let alone what happens after they deliver the information. The issue starts before the MEB in most cases. Most line commanders do not understand the MMRB process or chain of events leading to the MEB. This lack of understanding leads to delays, missed appointments, and, in some cases, a lack of accountability for soldiers and information. These persons are key to the process and must receive training and

education in order for them to keep their units as ready as possible and save the government money misspent on soldiers lingering in the MEB process.

Human Resource XXI Century Contract (HRXXI). Asking commanders to gather voluminous administrative information required by the PEB often slows the overall processing time in most cases. The PEB and USAPDA rely heavily upon this data to make a final decision regarding any case reviewed. Looking at the Air Force as a model for implementing information infrastructure available today, the Army could satisfy the need for information and speed the process while removing the soldiers' unit from a courier role by employing an automated system for personnel file transfer. Much of the necessary groundwork is completed in the Human Resource XXI Century Contract -- HRXXI. According to Susan Harvey, director of the HRXXI Business Unit, HRXXI is "a tool that an agency can use to meet its human-resources needs" to include maintenance of personnel records (Dickey, 2000, p. 13). The contract not only offers solutions for the MEB requirement, but also offers opportunities for Fort Lewis as an installation to improve its personnel processes. Applying this concept to the Army overall, such a move could afford consolidation of the three current Army PEBs, therefore offering payroll savings while improving service to the entire Army. This stance would mirror what the Air Force has in place if the Army positioned the sole PEB in the Washington, D.C. area close to the DCSPER. Regardless of whether the HRXXI contract is used, consolidation of PEBs is a viable topic of discussion. According to Charles Peck (personal communication, March 9, 2000) the issue may become a reality in the next few years, after the USAPDA leadership looks more closely at the impact of such a move.

Leadership. Leadership is clearly the most critical concern for improving the MAMC MEB process. Without significant leader involvement and emphasis, the importance is lost on many people and the program will likely not improve. Leadership is the intangible element creating ownership of the process and ensuring training programs exist. Madigan Army Medical Center is fortunate to have leaders who are actively interested in the MEB, and are taking steps to educate and improve physician and administrative personnel participation. As an example, the Chief of Orthopedics developed a MEB template for his physicians to follow when executing a MEB consult. Orthopedic injuries at Fort Lewis are responsible for greater than 50% of the MEB cases and the Orthopedic staff at MAMC is one of the best performers regarding meeting data sufficiency and time requirements. The investigator believes their performance is directly attributable to the leadership and tools provided.

Communication. Communication is important between the soldier and the MTF staff, between the MTF staff and the unit chain-of-command, and the soldier and his chain-of-command. Army Regulation 635-40, Personnel Separation (1990), directs the first two of these three relationships, but PEBLOs and physicians can only encourage the third. To ensure the command is educated and up to date on their soldiers' appointments, PEBLOs need to push information to the commanders and initiate communication. This is critical to ensure soldiers do not miss appointments and increase the duration of their MEB process. Keeping the command involved and acting more as a partner can make the process more efficient.

Case Management. Physical Disability Evaluation Liaison Officers are the case managers for MEB actions. The difficulty facing PEBLOS is that on average 30 new

cases begin every month. This translates into 90 active cases at any given time and only four PEBLOs. Tracking that many cases is not easy, but it is necessary. The PEBLO must possess an awareness of appointments, annotate actions in the soldier's MEB file accurately, and communicate with the chain of command as well as the soldier. The implied task is that the PEBLO and other MTF staff communicate among themselves. Case management can reduce missed appointments and ensure administrative information is gathered completely and in a timely manner.

Time Metric. The time standard for processing a MEB case is 30 days from dictation of the NARSUM until delivery to the PEB. This time constraint does not address the primary customer's needs. The true measure of important processing time begins when the soldier receives a P-3 or P-4 profile and ends when the USAPDA makes final disposition and PERSCOM issues orders. This period of time marks degraded unit readiness, as the unit is without the soldier's services.

The current method for reporting processing time requires computation to begin before all medical and administrative data are available. If the MTF has done everything in its power to prepare the MEB packet but is missing administrative data from personnel, the packet cannot go forward. The issue is that the responsible parties are not answering for their inefficiencies and the medical staff is absorbing the responsibility all alone. Madigan staff are reporting the delay and it reflects poorly on the MTF.

Sister Service Performance Standards. The Air Force and Navy both report better processing times than the Army. The Air Force offered detailed data for a small clinic as well as a medical center showing a processing time of approximately 21 days (J. Saylor, personal communication, September 30, 1999). The Navy did the same and reported an

average processing time of 29 days (E. Zerr, personal communication, March 13, 2000). The two services vary little in the actual process as compared to the Army, but a close review of the implementation of the MEB program reveals some interesting points of discussion.

The Air Force (AF) follows the same statutory and DOD guidance as the Army while conducting its medical boards. However, they interpret some of the guidance differently than the Army. Air Force physicians address only the primary disqualifying diagnosis in preparing medical boards. They do not allow the soldier to list all maladies and then perform a medical evaluation of all complaints (J. Saylor, personal communication, September 30, 1999). This greatly reduces MEB processing times. The MEB collects minimal administrative information as part of the MEB packet, thus further limiting the duration of the medical board process. Similar to the Army and Navy, the AF does require a letter from the service member's commander and a LOD investigation. The notable difference is the data minutia the Army requires. The personnel data is not attached to the AF MEB packet (J. Saylor, personal communication, September 30, 1999).

In addition to the variations in handling administrative data, there are certain differences regarding elements of the medical process. The AF does not require a full physical as part of the formal medical board process as long as the Preventive Health Assessment (PHA) is complete and up to date. The PHA is the result of a two-year study related to Putting Prevention Into Practice (PPIP)--a preventive medicine initiative (Preventive, 1997). Airmen receive a physical for the disqualifying injury or illness only, thus precluding them from presenting unrelated complaints (J. Saylor, personal

communication, September 30, 1999). On this point the investigator questions if the airman is truly being cared for. Asymptomatic health issues may go undiagnosed. The investigator agrees that non-boardable conditions should be addressed in the Veterans Administration hospitals after discharge from the service, but a complete physical should be performed regardless of the disqualifying injury or illness. Also, within the last six months of service, the Air Force disallows any elective surgery, thereby preventing unnecessary delays in processing medical board cases (AFI 48-123, 1994).

The AF Instruction (AFI) governing medical board processing is AFI 36-2902. The researcher asked Dr. Jack Saylor, the Chief, Boards and Exams at the largest AF medical facility, Wilford Hall Medical Center, in San Antonio, Texas, to describe the Air Force medical board process as outlined in AFI 36-2902. He offered the description of the AF process depicted in Figure 3 (J. Saylor, personal communication, September 30, 1999). The notable variation is evident in the beginning of the process when the airman suffers an injury and visits a physician. The physician has the ability to recommend reclassification or retraining directly to the squadron commander. The physician may do this if he determines the service member can no longer meet the physical guidelines for the assigned MOS, but does meet minimum AF physical qualification standards.

Department of Defense instructions require all of the services to forward MEB cases to a PEB for adjudication; however, the DOD instructions do not direct the number of PEBs each service must operate. The Air Force believes that one central board, co-located in San Antonio, Texas, with the Air Force Personnel Center, is the most effective option. Because the two entities are neighbors, the personnel data required to adjudicate

cases is available upon demand. According to Thomas Sonderegger[8] (personal communication, September 13, 1999), the Air Force decided a few years ago to no longer include all the personnel data the Army still requires. The AF determined the data was not used enough in adjudicating cases to warrant encumbering the process. Thomas Sonderegger has over four years experience interacting with both the Army and AF

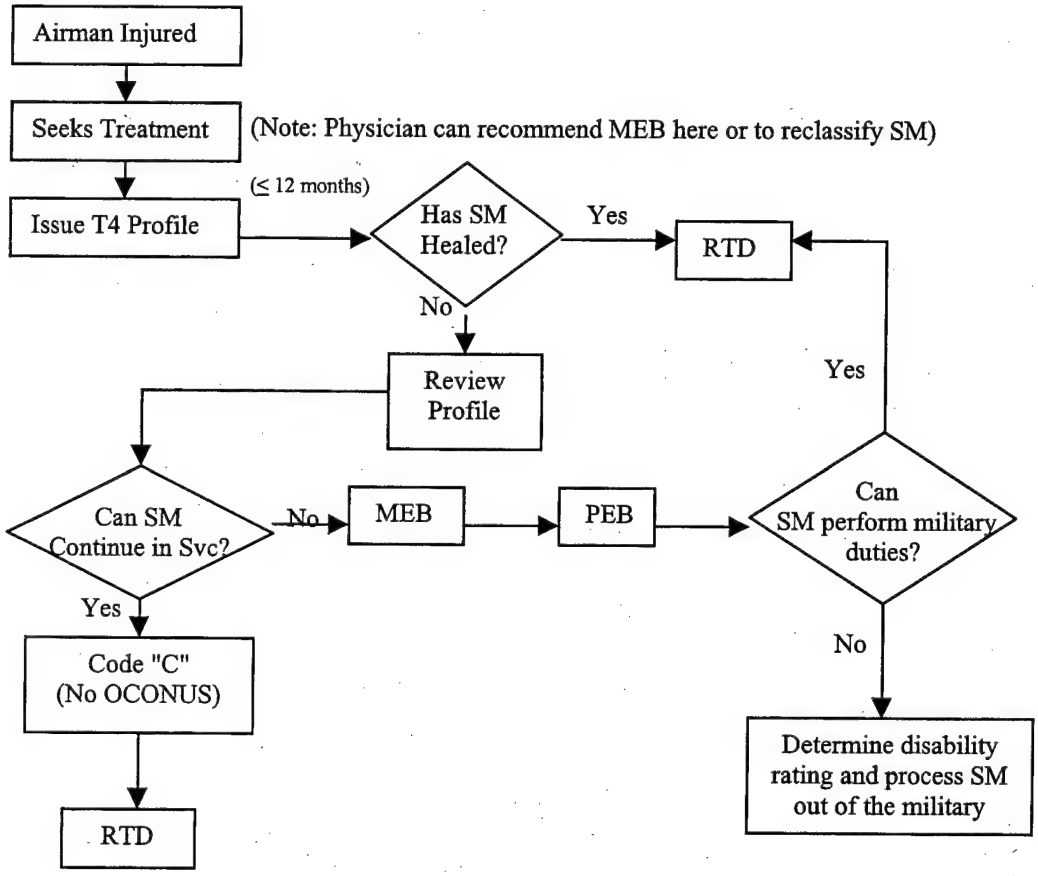

Figure 3. Air Force Medical Board Process

[8] Thomas Sonderegger is an AF Patient Administration Division (PAD) Non-Commissioned Officer in Charge (NCOIC) in the medical records section at McChord AFB, WA.

regarding processing medical boards. He indicated that most relevant personnel information is obtainable via automation, but even the remaining administrative documentation is easily accessible due to the close proximity of the two activities.

Like the Air Force, the Navy also follows the same statutory guidance and DOD instructions related to processing MEBs. The Navy MEB process is depicted in Figure 4. The primary document governing the Navy process is SECNAV Instruction 1850.4D (1998). A significant difference between the Navy and the other two services is that the Navy classifies retained seamen as suitable or fit. These classifications allow the Navy to retain on active duty seamen who are non-deployable (judgement of "fit" by the board). The Army does not practice retaining non-deployable soldiers as a rule. Another significant difference between the Navy and Army is that the Navy places seamen in a medical holding company while they undergo MEB activities (SECNAV Instruction 1850.4D, 1998). This ability allows close control and better case management than the Army system, thus explaining to some degree how the Navy performs so much better. The other reason may be that they give priority to MEB patients in the appointment process (Sanders, personal communication, March 10, 2000).

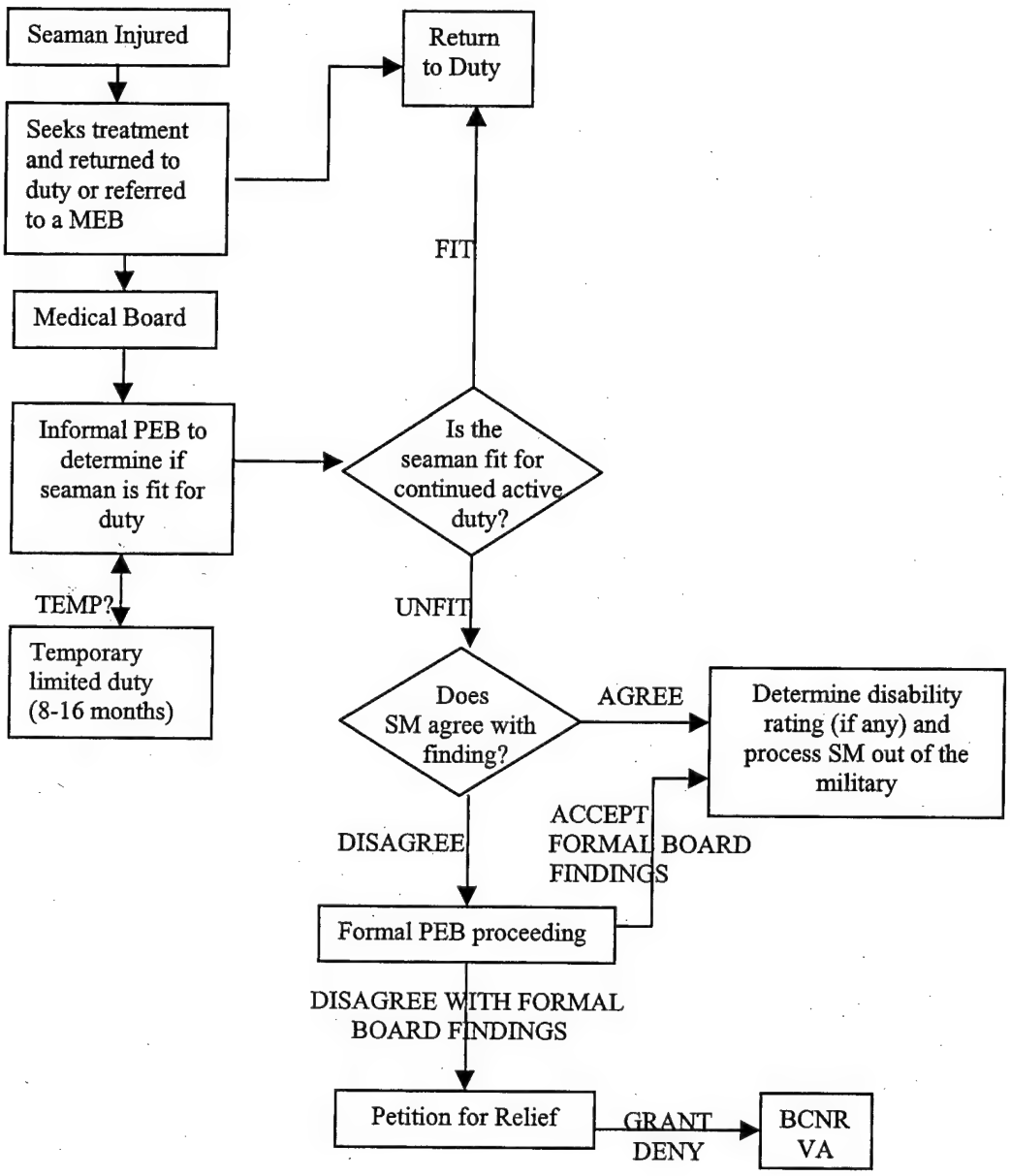

Figure 4. Navy Medical Board Process (SECNAV Instruction 1850.4D, 1998)

CONCLUSIONS AND RECOMMENDATIONS

Results and discussion of the medical evaluation board process at MAMC leads to five basic conclusions. These are listed below with recommendations addressing the shortcoming.

Madigan Army Medical Center has an excessively long processing time for MEB cases. To address this issue, the hospital should focus on disqualifying injuries and/or illnesses solely, and refer all other care to the Veterans Administration health system upon discharge of the soldier from the service.

Priority for medically related MEB cases is not the standard at MAMC. In those clinics and/or services not treating MEB related medical appointments as a high priority, a change in policy is recommended as a means of decreasing processing times.

Greater than 90% of all P-3/P-4 profiles issued result in a medical board. To save time, physicians issuing these profiles should initiate administrative paperwork for a MEB and hold it in suspense for 60 days (average time for a MMRB to refer cases to the MEB is 45 days).

Current standards for "counting" processing MEB time does not reflect the actual time a medical facility has responsibility for a medical board case. The methodology for tracking processing time should begin when the patient administration office is notified of the intent of a unit or physician to refer/begin a MEB on a soldier and end when the case is delivered to the Physical Evaluation Board.

Education on the part of unit command teams and many MAMC physicians is not adequate. Command teams at Fort Lewis need to receive training during their hospital in-brief/orientation on the MEB process and how they can influence and assist the

The MEB process at MAMC takes entirely too long although it is improving. The reason for the extended processing time appears mired in the strict interpretation of providing optimal medical care and conducting a complete physical. Medical Evaluation Board cases should address only those ailments rendering soldiers unfit for service, and allow follow up care to take place in the Veterans Administration medical facilities. The timesavings equate to cost avoidance and increased readiness.

Recognizing that the process is in fact long, it is important to note that the reported processing days reflect inconsistent record keeping by PEBLOs and inappropriate initiation of boards by physicians. Some physicians notify the PAD of intent to start a board long before they truly are ready and well before sufficient treatment has been delivered to determine if the soldier can return to duty in his MOS. This makes the processing time seem much longer than it is.

The above-mentioned deficiencies could be alleviated with better case management and training by the PEBLOs. These liaison officers do not consistently note in MEBITT all of the events transpiring, making follow up and management more difficult than necessary. The other action PEBLOs can take to make the process more efficient is opening communication with unit commanders. When a MEB referral is made, the PEBLO should send e-mail in addition to a written letter to the command. This approach ensures commanders receive the notification and facilitates the gathering of administrative information and the commander's letter. Active involvement of the commanders and first sergeants is important to ensure soldiers do not miss appointments as well. Unit leaders are not as knowledgeable as presumed and need MEB education.

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Raw Data

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
1	1	26	Army	SPC	6.50	71G	Ankle Injury	27	73	81	2	1	184
2	1	34	Army	SFC	13.50	11B	Low Back Pain	123	124	.50	.50	16	264
3	0	27	Army	PFC	1.75	52C	Shin Splints	131	107	1	6	7	252
4	1	38	Army	SSG	13.25	76J	Sleep Apnea	189	129	5	1	1	325
5	0	34	Army	SGT	12.00	92G	Cubital Tunnel Syndrome	56	132	1	.50	.50	190
6	0	21	Army	PV2	4.00	75H	1st Metatarsal - Cuneiform	217	86	1	5	19	328
7	0	38	Army	SSG	18.50	31R	Migranes	83	167	7	1	1	259
8	1	27	Army	SGT	10.50	91B	Arthritis	74	63	3	4	25	169
9	1	48	Army	SSG	16.00	91C	Type II Diabetes	230	145	1	21	2	399
10	1	22	Army	PFC	1.75	11B	Stress Fractures	139	58	1	5	4	207
11	1	35	Army	SSG	1.50	11C	Degenerative Joint Disease	134	64	1	13	2	214
12	1	24	Army	1LT	2.00	ORD	Back Pain	50	7	1	7	1	66
13	0	36	Army	SSG	17.25	71L	Ankle Pain	71	111	1	5	7	195
14	1	41	Army	SSG	9.00	93P	Ankle Injury	104	70	2	6	1	183
15	1	25	Army	SPC	1.00	98G	Abdominal Pain	116	29	1	44	28	218
16	0	27	Army	SPC	4.00	75H	Ankle Injury	223	84	1	6	1	315
17	1	25	Army	PVT	4.50	88M	Low Back Pain	168	56	1	5	29	259
18	0	27	Army	SPC	2.00	91B	Acute Inferior MI	240	56	1	12	1	310
19	1	21	Army	PFC	2.00	11C	Ankle Pain	229	158	3	2	1	393
20	0	26	Army	PFC	1.75	98G	Ankle Pain	288	1	35	1	99	424
21	1	19	Army	PFC	1.75	31F	Pes Planus	86	76	5	6	2	175
22	1	32	Army	SGT	12.75	31F	Degenerative joint Disease	35	90	6	1	11	143
23	1	46	Army	COL	25.00	CHEM	Tachycardia	116	88	7	15	1	227
24	1	41	Army	CW2	22.50	914A	Knee Pain	118	85	1	6	64	274
25	1	21	Army	SPC	3.50	52D	Enucleation, Right Eye	48	58	.30	.30	.30	107
26	1	41	Army	SFC	21.50	35W	Knee Pain	119	58	2	7	2	188
27	0	26	Army	SGT	8.50	92Y	Arthrofibrosh , Left Hip	48	62	1	4	2	117
28	0	36	Army	SGT	13.00	88M	Chronic Low Back Pain	112	47	1	6	1	167
29	1	29	Army	SPC	6.00	11B	Degenerative Disk	62	49	1	2	1	115
30	0	28	Army	SGT	7.00	88M	Knee Pain	90	56	1	6	37	190
31	1	21	Army	PV2	3.75	19K	Chronic Right Retropatella Pain	104	118	1	6	1	230
32	1	31	Army	SPC	2.50	31R	Hip Pain	112	69	2	55	63	301
33	1	33	Army	SGT	14.00	73C	Degenerative Disk Disease	8	45	7	12	8	80

(table continues)

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
34	1	28	Army	SPC	8.75	12B	Chronic Right Wrist Pain	78	45	5	9	35	172
35	1	21	Army	PFC	2.00	11H	Pes Cavus	145	54	1	1	8	209
36	1	21	Army	SGT	8.50	11M	Right knee Pain	141	43	6	8	21	219
37	1	33	Army	SSG	14.50	13F	Spondylolysis	142	16	1	5	89	253
38	0	35	Army	SSG	12.00	88N	Chronic Brachial Plexopathy	147	56	1	7	3	214
39	1	35	Army	SGT	13.00	88M	Chronic Low Back Pain	155	41	1	6	2	205
40	1	29	Army	SGT	12.00	92Y	Schizophrenia	52	4	1	121	1	179
41	1	25	Army	SPC	6.00	91B	Right Knee Pain ACL	130	30	2	6	1	169
42	1	38	Army	SFC	15.00	18E	Degenerative Arthritis	74	43	3	6	2	128
43	1	33	Army	SGT	14.25	92A	ACL Left Knee	104	58	1	1	5	169
44	0	34	Army	SGT	10.75	91E	Chronic Right Foot Pain	104	49	1	1	1	156
45	1	32	Army	SSG	13.00	91K	Chronic Low Back Pain	258	58	3	3	1	323
46	0	36	Army	SPC	5.50	91K	Chronic Left Shoulder Pain	190	63	2	3	8	266
47	1	26	Army	SGT	9.50	11B	Left Anterior Thigh Myositis	133	77	2	5	1	218
48	1	33	Army	SSG	11.50	11M	® Retropatellar Pain Syndrome	46	63	2	38	30	179
49	1	24	Army	SPC	5.25	92A	Low Back Pain	46	57	1	8	7	119
50	1	22	Army	SPC	4.50	91B	Bipolar Disorder	1	9	1	6	29	46
51	1	38	Army	SSG	17.25	11B	Type II Diabetes	58	82	1	1	1	143
52	1	26	Army	SGT	6.50	13F	Low Back Pain	93	79	3	1	18	194
53	1	37	Army	SGT	11.00	12B	Retropatellar Pain Syndrome	77	54	1	6	42	180
54	1	25	Army	SPC	7.00	11B	Degenerative Disk Disease	137	47	5	1	10	200
55	1	34	Army	SGT	9.00	91C	Chronic Low Back Pain	24	40	1	6	1	72
56	1	21	Army	SPC	3.75	88M	Bilateral Patellafemoral Pain Syndrome	8	55	1	1	8	73
57	0	20	Army	SPC	2.50	91B	Immunologic Reaction	250	63	5	7	21	346
58	1	28	Army	SPC	4.75	11B	Ankle Arthritis	98	28	6	5	18	155
59	1	36	Army	SSG	14.75	54B	Chronic Knee Pain	193	48	1	4	3	249

(table continues)

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
60	1	23	Army	PFC	4.25	11M	Chronic Right Heel Pain	66	1	1	33	3	104
61	1	25	Army	SPC	4.75	11B	Diabetes	170	19	.50	.50	1	191
62	1	24	Army	SPC	4.25	19K	Post Thoracotomy Pain Syndrome	289	126	1	17	1	434
63	1	24	Army	SPC	3.50	11B	Chronic Sternoclavicular Pain Syndrome	68	66	1	5	5	145
64	1	25	Army	SPC	7.00	35M	Chronic Low Back Pain	64	94	1	25	16	200
65	0	26	Army	SPC	3.00	91B	Chronic Trochanteric Bursitis	50	11	3	4	4	72
66	1	31	Army	SGT	12.50	31C	Systemic Sarcoidosis	71	27	1	5	1	105
67	1	29	Army	SGT	11.50	92Y	Bilateral Retropatellar Pain	72	59	3	1	4	139
68	1	29	Army	SPC	6.25	95B	Malunion Right Femoral Neck	54	.50	.50	3	1	59
69	1	23	Army	PFC	1.75	12B	Chronic Mechanical Low Back Pain	68	39	.50	.50	3	111
70	1	26	Army	SGT	8.50	62J	Chronic Low Back Pain	5	72	1	2	1	81
71	1	21	Army	SPC	2.00	74C	Malunited Fracture, Left Wrist	5	112	22	2	28	169
72	1	21	Army	PV2	2.00	62J	Bilateral Tibial Stress Reactions	80	30	1	46	6	163
73	1	21	Army	PFC	3.00	13B	S/P Burst Fracture	70	142	1	3	2	218
74	1	32	Army	SGT	12.25	92A	Retropatellar Knee Pain Syndrome	41	25	3	1	1	71
75	1	42	Army	SSG	17.00	95B	Chronic Left Calf Pain	83	33	3	5	1	125
76	1	38	Army	SGT	12.75	52D	Right Retropatellar Pain Syndrome	86	4	2	26	7	125
77	1	33	Army	SPC	14.00	92A	Retropatellar Pain Syndrome	135	25	2	34	69	265
78	0	22	Army	SPC	3.00	92A	Chronic Back Pain	3	25	2	50	42	122
79	1	26	Army	SGT	8.00	11M	Posterior Column Dysfunction	15	26	4	8	2	55
80	1	37	Army	SPC	2.25	11B	Chondromalacia	161	14	1	5	9	190

(table continues)

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
81	1	31	Army	SPC	13.00	62J	Osteoarthritis	9	18	3	6	1	37
82	0	26	Army	SPC	2.50	92G	Bilateral Femur & Tibia Stress Fractures	131	16	1	2	30	180
83	1	38	Army	SGT	13.50	63B	Chronic Right Ankle Pain	68	44	2	6	4	124
84	1	32	Army	SGT	10.50	71M	Chronic Foot & Ankle Pain	47	56	1	1	8	113
85	1	41	Army	SPC	2.25	11C	High Frequency Hearing Loss	1 60	3	3	1	18	185
86	1	19	Army	PFC	1.50	11B	Detached Retina	86	15	1	4	3	109
87	1	32	Army	SSG	14.50	18E	Left Parietal High Grade Glioma	1	55	1	10	3	70
88	1	25	Army	SPC	5.00	63W	Chronic Neck Pain	75	46	3	7	14	145
89	0	24	Army	SPC	6.00	92A	Pulmonary Sarcoidosis	21	45	2	3	1	72
90	1	40	Army	SSG	12.25	31F	Right Plantar Fasciitis	96	95	3	7	1	202
91	0	25	Army	CPT	2.00	MC	Bipolar II Disorder	144	2	23	31	10	210
92	1	20	Army	PFC	1.75	11B	Right SI Radiculopathy & Back Pain	152	52	3	2	1	210
93	0	20	Army	PFC	1.25	95B	Chronic Pubic Rami Stress Fracture	76	6	3	1	13	99
94	1	24	Army	SPC	4.25	13B	Osteochondritis Dissecans	72	56	8	7	28	171
95	1	48	Army	SFC	16.75	11B	Degenerative Joint Disease	267	21	1	1	5	295
96	0	36	Army	MAJ	12.00	QM	Degenerative Disk Disease	27	56	1	5	1	90
97	1	26	Army	SPC	7.25	35E	LZ Compression Fracture	92	80	1	1	1	175
98	1	27	Army	SSG	8.00	31U	Type II Diabetes	86	95	3	3	2	189
99	1	43	Army	MSG	16.00	13C	Myocardial Infarction	554	30	12	11	9	616
100	1	28	Army	SGT	9.00	88M	Asthma	117	28	4	11	1	161
101	1	36	Army	MAJ	14.00	AN	Myxomatous Mitral Valve Prolapse	21	48	.50	.50	1	71
102	1	25	Army	SPC	5.00	71L	Retropatellar Pain Syndrome	40	60	1	1	3	105
103	1	22	Army	SPC	3.00	92A	IA Nephropathy	152	35	2	5	1	195

(table continues)

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
104	1	25	Army	SPC	3.00	11B	Cervical Radiculopathy	42	34	3	8	1	88
105	1	29	Army	SGT	8.00	13B	Asthma	36	35	1	1	1	74
106	1	21	Army	PV2	1.25	11B	Ilio Tibial Band Syndrome	123	1	22	10	9	165
107	1	24	Army	SGT	5.00	19D	Ilio Tibial Band Syndrome	64	24	1	1	1	91
108	1	19	Army	PVT	1.00	63T	Severe Encephalopathy	1	27	4	2	6	40
109	1	31	Army	SPC	10.00	62J	Ankylosing Spondylitis	34	57	2	8	1	102
110	1	29	Army	SGT	6.00	11M	Ankylosing Spondylitis	40	29	1	1	1	72
111	1	27	Army	SGT	6.50	63B	Chronic Right Ankle Pain	98	45	1	1	3	148
112	1	19	Army	PFC	1.75	62B	Mechanical Low Back Pain	50	71	6	11	3	141
113	1	25	Army	SPC	2.25	11B	Bilateral Retropatellar Syndrome	50	70	2	1	1	124
114	0	27	Army	SPC	3.75	92A	Chronic Right Ankle Pain	101	24	3	18	1	147
115	1	20	Army	SPC	2.00	11B	IgA Nephropathy	49	38	3	1	1	92
116	1	22	Army	SGT	3.00	02D	Left Heel Fasciitis	47	64	1	2	1	115
117	1	27	Army	SGT	8.00	91P	Mild Asthma	133	30	6	4	22	195
118	1	28	Army	SPC	8.00	13B	Chronic Achilles Tendonitis	81	56	1	1	17	156
119	1	34	Army	SFC	13.75	18D	Cervical HNP	1	53	2	2	19	77
120	1	24	Army	SPC	6.50	13B	Chronic Low Back Pain	107	7	7	1	12	134
121	1	31	Army	SSG	10.25	19D	ACL Instability	60	29	1	1	1	92
122	1	30	Army	SPC	3.00	19K	Axis I Disorder	122	34	1	8	9	174
123	1	25	Army	SSG	7.00	62N	Axis I Disorder	28	30	1	3	1	63
124	0	32	Army	SPC	6.50	92A	Axis I Disorder	252	132	3	4	3	394
125	1	29	Army	SGT	9.00	11B	Chronic Bilateral Ankle Pain	124	131	3	26	1	285
126	0	33	Army	SPC	9.00	91P	Fecal Incontinence	110	50	6	7	1	174
127	1	38	Army	SSG	19.00	88M	Arthritis of the Knee	66	1	1	3	1	72
128	1	27	Army	SGT	8.00	31R	Retropatellar Pain Syndrome	19	60	3	1	1	84
129	1	20	Army	SPC	2.00	91B	Right Groin Pain	208	86	2	5	6	307

(table continues)

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
130	0	24	Army	SPC	5.25	91K	Retropatellar Pain Syndrome	90	21	2	14	48	175
131	1	25	Army	SPC	2.25	88M	Bilateral Plantar Fasciitis	140	23	3	2	1	169
132	1	21	Army	SPC	2.00	13F	Trench Foot	23	18	1	6	1	49
133	1	23	Army	PV2	1.25	11B	Retropatellar Pain Syndrome	14	20	1	6	1	42
134	1	27	Army	PFC	1.50	11B	Right MCL Sprain	115	3	3	1	14	136
135	1	24	Army	SPC	3.25	63B	Herniated Nucleus Pulposus	14	38	1	.50	.50	54
136	1	39	Army	SSG	16.25	12B	Low Back Pain	95	90	32	6	1	224
137	1	21	Army	PV2	2.00	11M	Chronic Plantar Fasciitis	50	43	1	2	1	97
138	1	21	Army	PV2	2.00	63B	Exercise Induced Angiodema	61	24	1	6	1	93
139	1	38	Army	SFC	16.00	79R	Stage II Hodgkin Disease	98	92	1	3	1	195
140	0	20	Army	PFC	1.00	95B	Bilateral Fibular Stress Fractures	24	17	1	3	3	48
141	1	27	Army	SSG	18.00	98G	Bronchial Carinoid Tumor	72	58	1	6	1	138
142	1	21	Army	SPC	1.75	12B	Retropatellar Pain Syndrome	139	59	4	9	1	212
143	1	43	Army	SFC	18.00	13F	Low Back Pain	52	113	3	5	2	175
144	0	29	Army	SPC	2.00	92A	Plantar Fasciitis	27	52	1	3	1	84
145	1	20	Army	PFC	1.00	11M	Genu Recurvatum	34	86	1	1	1	123
146	1	33	Army	SSG	13.00	97B	Thoracic Facet Syndrome	63	65	1	4	1	134
147	0	21	Army	SPC	2.25	98J	Low Back Pain	6	35	1	2	1	45
148	1	25	Army	SPC	4.75	63B	Retropatellar Pain Syndrome	13	152	1	2	1	169
149	1	49	Army	MAJ	24.00	EN	Andenocarc-inoma of Prostate	266	44	4	7	1	322
150	1	24	Army	PFC	1.00	95B	Neural Ecto Dermal Tumor	1	62	1	8	1	73
151	1	23	Army	PFC	2.00	13F	Chronic Knee Pain	67	33	1	1	1	103
152	1	32	Army	SGT	5.25	91P	Chronic Left Achilles Tendonitis	27	36	2	1	11	77
153	0	21	Army	SPC	2.00	95B	Degenerative Arthritis	13	94	1	13	1	122
154	1	27	Army	PV2	1.50	11B	Chronic Left Ankle Pain	36	37	2	4	43	122

(table continues)

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
155	1	36	Army	CW3	11.00	153DC	Chronic Low Back Pain	21	23	8	5	1	58
156	1	45	Army	SGT	12.50	88M	Osteoarthritis of the Knee	2	27	1	1	1	32
157	1	23	Army	SPC	3.75	98C	Chronic Right Shoulder Pain	16	30	50	.50	10	57
158	0	26	Army	SPC	9.00	31U	Left Knee Osteoarthritis	11	61	2	1	19	94
159	0	40	Army	SGT	8.50	92Y	Herniated Nucleus Pulposus	80	35	3	3	4	125
160	0	29	Army	SPC	5.00	91B	Chronic Hip Pain	37	40	2	6	6	91
161	1	41	Army	SGT	12.00	63T	Left Leg Pain	47	32	3	7	2	91
162	1	21	Army	SPC	1.75	11C	Anterior Tibial Periostitus	29	86	1	5	1	122
163	1	31	Army	SGT	11.00	12B	Cervical Radiculopathy	35	44	5	8	2	94
164	1	44	Army	SGM	21.00	11Z	Cervical Spine Glioma	1	5	.30	.30	.30	7
165	1	22	Army	SPC	2.50	11C	Asymptomatic ® Snapping Scapula	42	52	1	2	1	98
166	0	47	Army	SSG	14.00	91B	Sleep Apnea	81	25	5	7	1	119
167	1	25	Army	SPC	6.00	11B	Right Shoulder Instability	35	25	5	2	3	70
168	0	21	Army	SPC	3.00	96D	Stage II Hodgkin Disease	40	70	1	3	1	115
169	1	20	Army	PFC	1.00	11B	Degenerative Disk Disease	31	36	1	1	1	70
170	1	21	Army	PFC	2.00	11B	Stress Fractures	42	22	2	25	2	93
171	1	24	Army	SPC	4.75	63B	Bilateral Knee Pain	13	147	1	2	1	164
172	1	31	Army	SPC	1.25	91B	Bilateral Knee Pain	23	70	1	7	1	102
173	1	31	Army	SPC	10.25	14S	Hepatitis C	59	65	.50	.50	1	126
174	1	24	Army	SGT	5.75	75H	Asthma	56	101	53	2	1	213
175	1	21	Army	PFC	3.00	71G	Asthma	22	71	.50	.50	2	96
176	1	23	Army	2LT	1.25	----	Asthma	71	1	1	4	5	82
177	1	34	Army	SPC	3.50	11M	Bilateral Knee Pain	139	121	6	4	5	275
178	1	18	Army	PVT	1.25	92A	Schizoaffective Disorder	28	47	1	1	5	82
179	1	45	Army	CW3	23.00	920A	Vogt-koyanagi-harad disorder	142	94	1	5	1	243
180	1	34	Army	SGT	13.50	13B	Recurrent Shin Splints	45	57	1	1	1	105
181	1	----	Army	SPC	-----	-----	Low Back Pain	40	24	1	1	1	67

Note. The annotation of ----- denotes missing data in the reviewed records. (table continues)

ID	Gender	Age	Service	Rank	Time in Service	MOS	Diagnosis	(Days per Segment) T_1	T_2	T_3	T_4	T_5	T_6
182	0	20	Army	SPC	3.25	77F	Chronic Peroneal Tendonitis	21	59	1	1	1	83
183	0	39	Army	SSG	-----	92G	Degenerative Lumbar Disk	9	142	1	1	1	154
184	1	24	Army	SPC	5.50	91R	Thoracic Spine Degenerative	58	42	1	1	1	103
185	0	21	Army	SPC	2.25	54B	Lupus	40	2	1	1	1	45
186	1	-----	Army	SFC	-----	91D	Degenerative L5-S1 Disc	50	17	1	5	1	74
187	1	28	Army	SPC	10.25	88M	Right Knee Pain	59	32	.30	.30	.30	92
188	1	39	Army	SSG	-----	95C	Mechanical Low Back Pain	34	30	1	3	1	69
189	1	35	Army	CPT	15.75	MC	Degenerative Disc Disease	66	22	1	4	2	95
190	1	24	Army	SGT	4.50	13F	Degenerative Cervical Disc Disease	63	8	1	1	1	74
191	1	-----	Army	SSG	15.00	55B	Parkinson's Disease	52	13	16	6	70	157
192	0	41	Army	SSG	-----	91C	High Blood Pressure	99	271	13	1	13	397
193	1	-----	Army	SGT	-----	31U	Left Knee Pain	35	38	6	62	22	163
194	1	21	Army	PFC	3.00	91P	Bilateral leg Pain	37	3	1	20	8	69
195	1	39	Army	SFC	20.00	67T	IgA Nephropathy	103	34	13	46	25	221
196	1	20	Army	PVT	.75	12B	Back Pain	21	41	1	84	21	168
197	1	38	Army	SFC	15.50	11B	Congenital Stationary Night Blindness	125	1	1	21	7	155
198	1	28	Army	SPC	5.00	91K	Asthma - Exercise Induced	33	66	19	9	1	128
199	0	21	Army	PFC	2.25	75H	----------	37	54	1	11	1	104
200	1	-----	Army	SSG	24.50	55B	Bilateral Chronic Achilles Tendonitis	80	15	1	13	12	121

Note. The annotation of ----- denotes missing data in the reviewed records.

Madigan Army Medical Center

The Medical Evaluation Board Process and You

ARMY MEDICINE

This page has been prepared to educate Fort Lewis unit commanders, assist MAMC Physical Evaluation Board Liaison Officers (PEBLO) and physicians in processing disability cases and counseling soldiers. It is not intended to be used independently, but in conjunction with the current disability processing guidelines, regulations and standard operating procedures. See "References" section for a complete listing of documents governing the Physical Disability Evaluation Process.

DISABILITY EVALUATION SYSTEM BACKGROUND

Disability laws allow the Secretary of the Army to remove from active duty those who can no longer perform their duties because of a physical disability, in order to maintain a fit and vital force, and to fairly compensate members whose military careers are cut short due to a service-connected or service-aggravated physical disability. Chapter 61 of Title 10 U.S.C. is the mechanism and it applies to all grades, both active and reserve.

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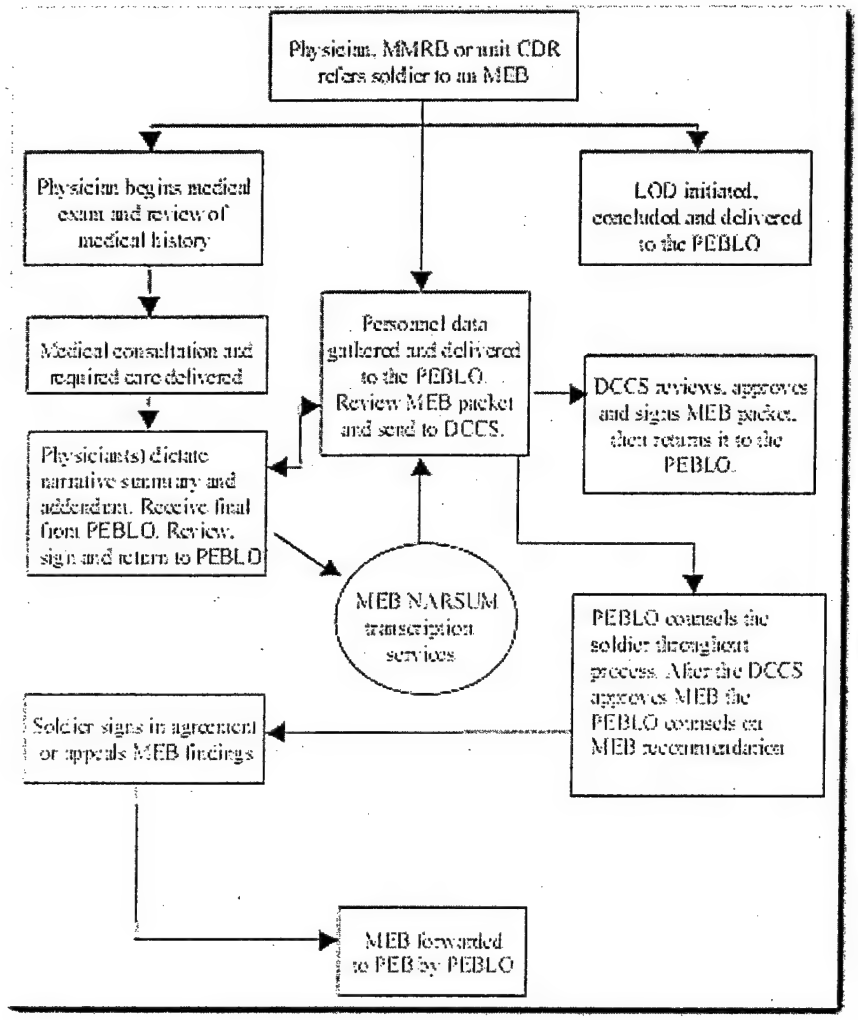
The MEB Explained

On this page you will find a basic explanation of the process, a Flowchart highlighting the numerous steps and players, and required elements to complete a MEB packet

What is a Medical Evaluation Board? A MEB is an informal proceeding consisting of at least two physicians evaluating the medical history of a soldier and determining how the injury/disease will respond to treatment protocols. During the course of the MEB, physicians refer to medical fitness standards contained in AR 40-501, chapter three (1998). The regulation lists various medical conditions and physical defects that may render a soldier unfit for military duty.



To the left is flowchart illustrating the steps involved with processing a MEB case. Some of the steps may be repeated due to the difficulty of a case or requests for more information. The DOD sets an allowable time for processing MEB cases at 30 days.

What determines if a person is fit or unfit for duty? According to DODD 1332.18 (1996), the sole standard for making determinations of unfitness due to physical disability is based on ability to perform the duties of the service member's office, grade, or rank because of disease or injury. This is where the process begins.

Following the diagram, the physician examines the soldier, initiates necessary consults from other departments, orders a complete physical, and reviews the soldier's medical history. The Clinical information collected must include "a medical history, appropriate physical examination, medical tests and results, all consultations, diagnoses, treatment and prognosis" (DODI 1332.38, 1996, E3.P1.2.3). To ensure standardization, physicians who prepare MEBs are encouraged to use the Department of Veterans Affairs' Physician's Guide for Disability Evaluation Examinations to indicate the nature and degree of severity of the soldier's condition.

Once all of the necessary activities are complete, the physician dictates the narrative summary (NARSUM). This NARSUM is typed and sent through the PEBLO for review. The PEBLO checks the NARSUM for completeness and accuracy then sends the NARSUM to the dictating physician. The physician reviews the NARSUM and if he believes it is accurate, signs it and returns the document to the PEBLO.

The PEBLO is responsible for case management of the soldier. PEBLOs annotate significant dates and assist soldiers in getting medical appointments. They are the first to know if the process has slowed or halted. Throughout the process the PEBLOs keep soldiers informed and communicate with the soldier's unit. When the PEBLO has a complete MEB packet, he takes the

case to the Deputy Commander for Clinical Services (DCCS) for review. The DCCS is the final approving authority on the MEB case and must signify his approval before the packet goes to the Physical Evaluation Board (PEB). Once the PEBLO receives the approved MEB case from the DCCS, he counsels the soldier on the findings. If the soldier agrees, he signs and the case is sent to the PEB.

What is Required in a MEB Packet

MEB packets submitted to the PEB must include a complete narrative summary of the case. In reaching any conclusions, physician(s) must consider all medical examination evidence, medical history, results of x-rays and laboratory tests, reports of consultations, and responses to therapy. More than just medical information is required to complete a MEB packet. As described below, several requirements must be met by the servicing personnel center and the unit commander.

As outlined in DODI 1332.38 (1996), MEB packets forwarded to the PEB shall include the following information:

1. Member's name, rank, grade, and social security number;
2. Specialty of the signatory physicians;
3. Clinical department or service;
4. Medical treatment facility and its location;
5. Date MEB was conducted;
6. Copy of the line of duty determination;
7. Letter from the soldier's commander describing how the member's medical condition impacts job performance and deployability status;
8. Military history to include date of first and most recent entry into the service; estimated termination of service; administrative actions ongoing, pending, or completed;
9. Chief complaint, preferably stated in the soldier's own words;
10. Social information including living arrangements, marital status, leisure activity, acquaintances, substance use or abuse, police encounters/record;
11. Functional status of the soldier;
12. Statement regarding prognosis for functional prognosis post-treatment period;
13. Stability of current clinical condition;

14. Statement of compliance with treatment recommendations and reasonableness of any refusal of recommended treatment procedures;

15. Requirement for monitoring including frequency of indicated treatment and/or therapy visits and associated operational assignment limitations; and

16. Official documents identifying next of kin if service member is legally incompetent.

REFERENCES

The references listed below are the governing statutory, regulatory and DOD directives supporting the PDES. They are listed by number and title. To view these documents electronically, click on your choice.

AR 40-501	Standards of Medical Fitness
AR 40-3	Medical, Dental, and Veterinary Care
AR 600-60	Physical Performance Evaluation System
AR 635-40	Personnel Separations
DOD Directive 1332.18	Separation or Retirement for Physical Disability
DOD Instruction 1332.38	Physical Disability Evaluation
DOD Instruction 1332.39	Application of the Veterans Administration Schedule for Rating Disabilities
Chapter 61, Title 10 USC	Retirement or Separation for Physical Disability
I Corps Commander's Guide	MMRB Instruction for Commanders (1998)

* Click the banner above for VASRD information

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Physical Evaluation Board Liaison Officer (PEBLO) Information Page

General Information

This page is intended to assist the Physical Evaluation Board Liaison Officer (PEBLO) in processing disability cases and counseling the soldiers. This page is not intended to be used independently, but in conjunction with the current disability counseling information, DoD Directive 1332.18, Separation from the Military Service by Reason of Physical Disability; and other applicable Army directives.

Slide presentations from the 1999 Worldwide PEBLO Conference are available through the MEDCOM PAD link.

PEBLO ITEMS OF INTEREST

MEB Survey | PEBLO Guide

PEBLO Training | References

Imminent Death | MEDCOM PAD

*The USAPDA also has a policy letter on handling requirements for imminent death cases. Click the banner below to view the document.

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The Unit Commander's Role

On this page you will find a discussion of the important role unit commanders play in the MEB process. Specific areas of interest are listed below with hyperlinks to the subject. Thank you for browsing the site. If you have questions, please call the MAMC PAD office @ 968-1673/1679.

To move to specific areas of interest, click on the link below. At the bottom of this page is a menu bar to aid your navigation throughout this site.

- MMRB Leads to MEB
- Administrative Information Required
- Communication
- MEB Points of Contact

How a MMRB Refers A Soldier to A MEB

Generally, when a soldier receives a P-3 or P-4 profile, you the commander should know that your soldier is going to be scheduled for a MMRB. When you get a copy of the soldier's P-3 or P-4 profile, ask the soldier if their physician is referring the case to a MEB. If not, then check with I Corps strength Management office for a scheduled MMRB date and a list of requirements for you the commander. To view the I Corps Commander's Guide on this subject, click here ●If the document is difficult to read, save it to your hard drive or disk and view at an enlarged size (75% or 100%).

The general time line from issuance of the permanent profile to adjudication by the MMRBCA is greater than 45 days. When Strength Management receives the profile it schedules a board appearance. Boards convene every two weeks. After the board convenes, the recommendations go to I Corps for approval. Generally, it takes 30 days from the time the results are sent to I Corps until the MEB referrals reach the hospital.

Within I Corps, greater than 90% of soldiers reporting to a MMRB get referred to a MEB. Understanding this can help you get prepared. Shortly after your soldier goes to the MMRB

you should contact the MAMC PEBLO office and ask what administrative information and letters are required from you for the MEB packet. If you do this and complete the requirements, you can have your portion of the MEB packet finished by the time the MMRB findings come back from I Corps. If the MMRBCA refers your soldier to the MEB, you just saved significant time in getting the soldier through the MEB process. This time is important because it impacts how quickly your soldier is processed and therefore how soon you can get a replacement.

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Administrative Information Required

At a minimum, the commander is responsible for the following items included in the MEB packet:

1. Copy of the Line of Duty Investigation determination;
2. Commander's Letter describing how the soldier's medical condition impacts job performance and deployability status;
3. Military history (generally this is the personnel file or 2-1 information) to include date of first and most recent entry into service; ETS; any administrative actions ongoing, pending, or completed; and
4. APFT score cards for the past three years.

This list may not be all-inclusive and should not be used independently of MAMC PEBLO information.

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Communication

Communication among the command, soldier, and MTF is paramount for quickly processing soldier through the MEB process. All commanders need to be aware of soldiers undergoing a MEB. Make it a point to stay abreast of appointments (use PLs and PSGs) and get the 1SG involved as necessary. In most cases the hospital attempts to provide priority appointments for MEB soldiers, but that is not always possible. The TRICARE access standard for TRICARE Prime enrollees is 30 days for routine appointments. Most of your soldier's appointments related to the MEB will be routine. Missing an appointment can extend the process unnecessarily. If you have questions regarding your soldier's appointments, call his or her assigned PEBLO. PEBLOs track appointments and should be able to tell you the status of your soldier's MEB. If you feel that you have a lack of information call the PEBLO and encourage him or her to push information to you.

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MEB Points of Contact

Position	*Name*	*Office Number*	*Responsibilites (Alphabetical)*
Chief, Patient Affairs	*CPT Tisby*	*968-1683*	*Staff Management*
PEBLO	*Ms. Lynda Henson*	*968-1679*	*MEB cases (A-F)*
PEBLO	*Ms. Debbie Burnham*	*968-2026*	*MEB cases (G-J) Med Hold*
PEBLO	*Ms. Patti Burkhart*	*968-3437*	*MEB cases (K-S) TDRL*
PEBLO	*Mr. Mike Reninger*	*968-3649*	*MEB cases (T-Z) Misc.*

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UNIT CDR LEGAL PHYSICIAN

The Legal Assistance Help Page

This page is made available as an explanation of the legal perspectives regarding the PDES and the PEB specifically. If you cannot find your answer here, please call the assigned PEBLO at MAMC for the appropriate name and phone number for legal counsel. The PEBLO is not a source of legal information. For more information on the PDES, please visit the United States Army Physical Disability Agency homepage.

Physical Evaluation Boards Explained

Choose a hyperlink to move directly to a specified section of this page

Introduction

The functional proponent for the Physical disability Evaluation System is the U.S. Army Physical Disability Agency, FGS-WRAMC, WASH DC 20307-5001. A point of contact for information on physical disability evaluation policy and procedures is Major Dennis, Policy Officer, DSN 291-5133/5169 or commercial (301) 427-5133/5169. The Agency maintains a file copy of individual case processing for five years and a computer database of disability processing back to fiscal year 81.

a. Soldiers enter the Physical Disability Evaluation System four ways.

(1) Referred by a Medical Evaluation Board (MEBD). When a soldier has received maximum benefit of medical treatment for a condition that may render a soldier unfit for further military service, the medical facility (MTF) conducts a MEBD to determine whether the soldier meets the medical retention standards of AR 40-501, chapter 3. If the soldier does not meet medical retention standards, he or she is referred to a Physical Evaluation Board (PEB) to determine physical fitness under the policies and procedures of AR 635-40.

(2) Referred by the MOS/Medical Retention Board (MMRB). The MMRB is an administrative screening board a soldier's command to evaluate the ability of soldiers with permanent 3 or 4 medical profiles to physically perform in a worldwide field environment in their primary military occupation specialty. referral to a MEBD/PEB is one of four actions the MMRB Convening Authority may direct. It the MMRBCA directs referral to a MEBD/ PEB, conduct of the PEB is mandatory whether or not the soldier meets medical retention standards.

(3) Referred as the result of a fitness for duty medical examination. When a commander believes a soldier of his or her command is unable to perform MOS related duties due to a medical condition, the commander may refer the soldier to the MTF for evaluation. If evaluation results in a MEBD, and it determines that the soldier does not meet medical retention standards, the soldier is referred to a PEB.

(4) Referred as a result of HQDA action. The Commander, PERSCOM, upon recommendation of The Surgeon General, may refer a soldier to the responsible MTF for medical evaluation as described in (3) above. PERSCOM also directs referral to a PEB when it disapproves the MMRB recommendation to reclassify a soldier.

b. When a soldier is referred for a MEBD/PEB, the Physical Evaluation Board Liaison Officer (PEBLO) assigned to the MTF counsels the soldier on MEBD/PEB findings and the related rights and benefits. If the MTF determines that the soldier is not mentally competent, the PEBLO counsels the designated next-of-kin.

c. A soldier is physically unfit when a medical impairment prevents reasonable performance of the duties required of the soldier's office, grade, rank, or rating.

d. Notwithstanding the above, when a soldier is referred for physical disability evaluation after having applied for length of service retirement or who is within nine months of mandatory retirement or who has been approved for certain separation actions, the soldier enters the disability system under the presumption that he or she is physically fit. This is known as the Presumption of Fitness Rule.

(1) The soldier is presumed fit because he or she has continued to perform military duty up to the point of separation for reasons other than physical disability.

(2) The presumption originated in 1973 as a result of Congressional dissatisfaction over general officers retiring for physical disability when they were eligible for length of service retirement. It was incorporated into the DOD Directive governing military disability evaluation and applies to all soldiers.

(3) The philosophy behind the rule is that military disability compensation if for career interruption, compensation for service-incurred conditions. The latter falls under the purview of the Department of Veterans Affairs.

e. Application of the Presumption of Fitness Rule does not mandate a finding of unfit. The presumption is overcome if the preponderance of evidence establishes either of the circumstances described below per DOD Directive 1332.18.

(1) The soldier, because of disability, was physically unable to perform adequately the duties of office, grade, rank or rating. This circumstance is aimed at long-term conditions. Efficiency reports and/or other performance related evidence must show that the soldier was not reasonably performing the duties of his or her office, rank, grade, or rating. Essentially, the burden of proof is on the soldier to establish unfitness. Ability to perform duty in the future is not an issue under this circumstance.

(2) Acute, grave illness or injury, or other deterioration of the soldier's physical condition occurred immediately prior to or coincident with processing for separation or retirement for reasons other than physical disability which rendered the soldier unfit for further duty. Future duty is a factor in this circumstance.

f. Once a determination of physical unfitness is made, the PEB is required by law to determine the physical disability rating using the Veterans Schedule for Rating Disabilities (VASRD).

g. Physical disability disposition--retirement or separation with severance pay--is based on the criteria set forth in 10 USC chapter 61. The 15-year retirement plan does not apply to soldiers who are determined physically unfit.

h. Per 10 USC chapter 61, three factors determine disability disposition: the rating percentage, the stability of the disabling condition, and total years of active federal service. For service-incurred or aggravated conditions not involving misconduct, the dispositions are described below.

(1) Permanent disability retirement occurs if the condition is permanent and stable and rated at a minimum of 30 percent or the soldier has 20 years active federal service.

(2) Temporary disability retirement occurs if the soldier is entitled to permanent disability retirement except that the disability is not stable for rating purposes. However, stability does not include latent impairment -- what might happen in the future.

i. If placed on the TDRL, the soldier is require to undergo a periodic medical reexamination within 18 months followed by PEB evaluation.. The soldier may be retained on the TDRL or final determination made. While the law provides for a maximum tenure on the TDRL of 5 years, there is no entitlement to be retained for the entire period.

j. Military disability compensation is based on disposition, rank, and years of service.

(1) For permanent retirement or placement on the TDRL, compensation is based on the higher of two computations: disability rating times retired pay base; or the years of service percentage computation (2.5 x years of service) times retired pay base. Soldiers on the TDRL receive no less than 50 percent of their retired pay base. Retired pay base depends upon when the soldier entered the service. For soldiers on active duty prior to 6 September 1980, it is the basic pay of the highest rank held.

(2) Disability severance pay equals 2 months basic pay for every year of service not to exceed 12 years.

k. The PEB, composed of a field grade president and personnel management officer and medical member, initially conducts an informal adjudication. This is a records review of the MEBD and applicable personnel documents without the soldier present. The informal decision is forwarded to the PEBLO for counseling of the soldier.

l. If the soldier concurs with the findings, the case is forwarded to the Physical Disability Branch (PDB), a part of the U.S. Army Physical Disability Agency (USAPDA), to accomplish disposition.

m. If the soldier disagrees with the findings, the soldier has the right to submit a rebuttal for reconsideration and the right to elect a formal hearing. At the time of election for a formal hearing, the soldier may also elect to appear or not appear and to be represented by the regularly appointed military counsel or to have counsel of his choice at no expense to the government. He may also request essential witnesses to testify in his behalf.

n. If the soldier agrees with the findings of the formal hearing, the case is forwarded to PDB for disposition. If the soldier does not agree and submits a statement of rebuttal, the case is forwarded to USAPDA for review.

o. If USAPDA review confirms the PEB findings, the case is forwarded to PDB for disposition. If USPDA modifies the PEB findings, the revised findings are forwarded to the soldier for election. If the soldier does not concurs and provides a statement of rebuttal, the case will be forwarded to the U.S. Army Physical Disability Appeal Board for final decision if the rebuttal does not result in a reversal of the modification.

p. While both the Army and the Department of Veterans Affairs (DVA) use the VASRD, not all the general policy provisions set forth in the VASRD apply to the Army. Consequently, disability ratings may vary between the two agencies. The Army rates only conditions determined to be physically unfitting, compensating for loss of a career. The DVA may rate any

service-connected impairment, thus compensating for loss of civilian employability. Another difference is the term of the rating. The Army's ratings are permanent upon final disposition. DVA ratings may fluctuate with time, depending upon the progress of the condition. Further, the Army's disability compensation is affected by years of service and basic pay; while VA compensation is a flat amount based upon the percentage rating received.

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PEB FORMAL BOARD INFORMATION SHEET

Please fill out the following information to assist your attorney in preparing your case. Bring this questionnaire and other items you gather with you to your interview.

a. RESULTS OF THE INFORMAL BOARD:

b. WHAT DO YOU WANT TO ASK FOR AT THE FORMAL?

c. WHAT ARE THE DUTIES DAY-TO-DAY IN YOUR PRIMARY MOS?

d. WHICH OF THOSE DUTIES CAN/CAN'T YOU DO BECAUSE OF YOUR MEDICAL CONDITION(S)? (LIST EACH CONDITION SEPARATELY)

e. IN THE PAST YEAR, HOW MANY TIMES HAS YOUR MEDICAL CONDITION CAUSED YOU TO:

1. MISS WORK TOTALLY:

2. LEAVE WORK EARLY:

3. NOT PERFORM SPECIFIC TASKS/MISSIONS: (WHO FILLED IN FOR YOU ON THE TASKS?)

4. VISIT THE EMERGENCY ROOM:

5. BE HOSPITALIZED:

f. HAVE YOU BEEN COUNSELED BY YOUR SUPERVISOR/1SG/CO REGARDING HOW YOUR MEDICAL CONDITION IS AFFECTING YOUR PERFORMANCE? IF SO, BRING THE COUNSELING STATEMENTS WITH YOU

g. HAS YOUR MEDICAL CONDITION BEEN MENTIONED ON YOUR OER/NCOER? IF SO, BRING THE OER/NCOER WITH YOU.

h. WILL YOUR CDR/1SG/SUPERVISOR ETC WRITE A MILITARY MEMORANDUM DESCRIBING EXACTLY WHICH OF YOUR TASKS/DUTIES YOU CAN OR CAN NOT PERFORM DUE TO YOUR MEDICAL CONDITION(S)? PLEASE GET THESE LETTERS BEFORE COMING TO THE BOARD. ALSO GIVE ME:

POSITION/TEL # (DSN AND COMMERCIAL)

1.

2.

3.

4.

5.

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THE PHYSICAL EVALUATION BOARD FORMAL HEARING

1. This memorandum contains important information that you should know before you appear for your formal hearing at the Physical Evaluation Board (PEB). In order to have the best chance to meet your desired goal, you should begin taking steps to prepare for your formal hearing.

2. You will have an attorney assigned to you. This attorney is not a member of the board. Their job is to educate you about the physical disability system, advise you on your options, represent you at your formal hearing, and counsel you on your rights and options after your formal hearing. The attorney is on your side and will provide the necessary information so you can make an informed decision.

3. The PEB has two purposes: to determine whether or not you are fit for duty, and ii you are unfit, to determine what disability Compensation you are entitled to receive. The PEB cannot address issues such as lack of treatment or mistreatment by medical personnel, reclassification to another MOS, or changing a finalized line of duty.

4. The standard the PEB must use in determining fitness is whether you can reasonably perform the duties of your office, rank, grade, or rating. The PEB can be better described as a performance evaluation board -- it will only find you unfit for duty if you cannot reasonably perform your job due to a *medical* condition.

a. This decision is made by relating the nature and severity of your medical condition to the requirements and duties you may reasonably be expected to perform in your primary MOS. As a reference, the PEB uses AR 611-201 to determine what duties you perform in your MOS and the physical requirements of

those duties. Therefore, while a certain medical condition may make an 11B unfit, the same condition may not make a 71L unfit.

b. While the ability to do PT, take the APFT, perform basic soldier skills, or be worldwide deployable may impact on the determination of fitness, they do not by themselves make you unfit for duty. For example, if a soldier is unable to take the APFT, he is still fit for duty if he can perform his MOS.

c. You must also remember that this determination is also based on your rank. Usually, the higher the rank, the less physically demanding the job. Therefore, a certain condition may make a PFC unfit, but that same condition may not make a SSG unfit.

5. The PEB can only consider conditions that are listed on the MEB, Narrative Summary (NARSUM), or any official addendum. Conditions that are not listed on these documents as "diagnosis" cannot be considered. Therefore, if you have an undiagnosed condition, see your physician so an addendum can be written.

6. If you have more than one diagnosed condition, the PEB will only rate those conditions that make you unfit for duty. To determine this, the PEB will determine what condition(s) ended your career. Therefore, it possible for a soldier with several different medical conditions to be found unfit for only one of them. You must remember that just because you have a medical condition, it does not mean you will be compensated, it first must make you unfit for duty.

7. The second function of the PEB is to determine what disability compensation you are entitled to if you are found unfit. If you are found unfit, the PEB will use AR 635-40 and DOD Dir. 1338.18 to determine whether the medical condition was caused or permanently aggravated by the service. If you are found unfit by reason of physical disability neither incurred nor aggravated during your service, you will be separated without benefits. However, if the condition was caused or aggravated by service, then the PEB will use AR 635-40, DOD Dir. 1338.18 and the VA schedule for Rating Disabilities (VASRD) to assign an appropriate rating. This rating is determined by your condition and its severity.

8. You are entitled to severance pay if you receive a rating of less than 30%. Therefore, soldiers with a 0%, 10%, or 20% rating will receive the same amount of severance pay. Severance pay is calculated by taking 2 months of basic pay times the number of years of active duty service up to 12 years (6 months or more counts as a whole year). If you receive a disability rating of 30% or more, you are entitled to disability retired pay. If you are eligible for retirement, speak to your attorney about how your disability compensation is calculated.

9. While it is your absolute right to request a formal hearing, there are certain risks associated with having a formal hearing. The PEB can change the informal findings in any way that is appropriate based on the evidence and the regulations. The PEB will review your case in its entirety. The PEB can increase or decrease your disability rating, find an unfit soldier fit and vice versa. You must remember that the PEB must evaluate your present medical condition. They cannot consider how you were in the past nor speculate how your condition will be in the future.

10. While you should speak to your attorney about what you should do to help your case, listed below are some general guidelines for whatever evidence you should try to obtain. Keep in mind that you will have the best chance to change the informal findings by producing new evidence. While your testimony alone may change the outcome, it is often not enough

a. If you were found fit and want to be unfit:

1. Letters from commanders/supervisors that indicate you are unable to perform in your MOS due to a medical condition. This statement should be specific on what condition is preventing you from performing and what duties you are unable to perform.

2. Your latest NCOERs/OERs that reflect your duty performance has been hindered by a medical condition.

b. If you are unfit but believe you are entitled to a higher disability rating:

1. Additional medical evidence showing your condition is much worse than originally diagnosed or described in your NARSUM.

2. Documentation of hospital/ emergency room visits, being put on quarters, and physical therapy records since your MEB was dictated.

3. Copies of your VA treatment records, including your disability award letter(s)

c. If you want to be found fit:

1. Letters from commanders/supervisors which indicate that you are able to perform in your MOS, and you are participating in unit PT and field exercises.

2. A new permanent profile which reduces your assignment/activity limitations

3. A copy or your PT card showing you have recently passed the APFT

4. Your latest NCOER/OER

11. If you obtain this evidence prior to your formal board, contact your attorney. Your attorney may submit this information to the PEB for reconsideration and have the informal decision changed without the need of having your formal board. If you are thinking about bringing witnesses to your hearing, contact your attorney ASAP to discuss this possibility with them.

12. While the PEB only needs your NARSUM to adjudicate your case, they should also have your medical records and portions of your personnel records. However, you should bring any

copies of these records that you think are relevant to your case. Discuss any adverse information (i.e. article 15's, QMP actions, bars to reenlistment, letters of reprimand, and information that would incriminate you in the commission of a crime) with your attorney. You should be totally honest with your attorney about these matters because they could have an impact on your case.

13. Requests to delay your formal board must be submitted in writing to: President, Physical Evaluation Board, Fort Sam Houston, Texas 78234. However, these requests will generally not be granted. Extraordinary reasons must exist to justify a delay. Additional time to get new medical evidence will usually be denied. If you need further treatment, speak to your doctor to see if he will recall your case.

14. If you still desire a formal hearing, you must arrive at the PEB NLT 0800hrs on the weekday prior to your formal hearing for the interview with your attorney (if your formal board is on a Monday - report on Friday). The uniform for that day is civilian attire. At your interview, your attorney will prepare you for your formal board. He/she will explain to you reporting procedures, how the board is conducted, and what will be covered at your formal hearing. If you have requested a nonpersonal appearance, contact your attorney ASAP. While it is your right to request such a hearing, a personal appearance is recommended.

16. The PEB's findings and recommendation may be reviewed by the U.S. Army Physical Disability Agency (USAPDA). This review occurs whether or not you appeal the PEB's findings after your formal hearing or even choose to have your formal hearing. However, the USAPDA must review the case if one or more of the PEB members disagree with the other board members (a minority report is filed) or if you appeal the formal board findings.

17. The USAPDA will review the entire record. However, you will not personally appear before the USDA. Because any appeal to the USPADA is done in writing be prepared for your formal hearing. Do not assume that you will get better results with the USAPDA. Like the PEB, the USAPDA can change the findings of your case in any way that is appropriate.

18. No matter what the final disposition of your case is, we cannot emphasize the importance of going to the Veteran's Administration. You may be entitled to benefits from the VA that you cannot receive from the Army. While your attorney can provide some guidance, you should contact your local VA disability section.

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SOME HELPFUL HINTS FOR THE PEB PROCESS

The board places a great deal of weight on a soldier's credibility. It is important for a soldier to answer questions honestly and consistently. Sometimes the same question is asked in more than one way to see if a soldier is consistent. Also the board will compare testimony to medical or personnel records. The key rule: is to answer a question honestly, and also insure that the answer is correct.

1. Be prepared to answer any of these questions:

a. What do you want the board to do for you? This question may mean that particular board member is not sure what he is going to do. The board member that asks the question probably does not think that the condition is as severe as the soldier says.

b. How much work/school have you missed because of your medical condition (other than in preparation for the MEBD/PEB)?

c. Any time from work missed because of medical appointments, quarters, going home early etc. If you have quarters slips bring them to the hearing

d. When is the last time you went to the Emergency Room? The board believes that the more severe the condition, the more often a soldier will need to go to the ER. Big focus for medical member.

e. When is the last time you went to the doctor? The more often a soldier sees the doctor usually the means the condition is worse.

f. What medication did you take today? (day of the formal) What did you take yesterday? -- looking to see if the soldier needs to take medication and that they in fact are taking it. If soldier says they are in pain then they will take some kind of medication even Tylenol/aspirin.

g. When did you get your prescription refilled last? -- looking to see how much medication the soldier takes. If the soldier says they take three pills a day and prescription has not been refilled in months; may show condition that is not severe. May impact negatively on soldiers credibility.

h. Is the pain constant? -- pain is very rarely constant. There are usually times that are better or worse. -- can say that always have pain, but activities such as running, lifting etc. make it worse.

i. What type of exercises do you do? -- applies to orthopedic injuries when a soldier goes to, or went to, physical therapy. -Board wants to see what the soldier is doing to help with his injury. Board places a great deal of emphasis on soldiers trying to improve their condition. Soldier should be able to describe the specific stretches or exercises they do. If the soldier can't describe them then it shows the board the soldier may not do any exercises.

j. What are you going to do when you get out of the Army? -Board may be looking to see if the soldier has made any definite plans. If the soldier has, the board may say that the plans and not the injury is the reason for the soldier wanting to get out. If the soldier has definite plans, and they involve physical labor it may show that the condition is not that severe.

k. Have you ever injured your back before? This relates to credibility. If the soldier says no, the board may be skeptical of any other testimony. Everyone has strained their back in day to day living/exercising. A good reply might be I had some minor muscle pulls (moving furniture type). Careful if the injury you describe is serious, you risk a finding that the current condition existed prior to service.

l. What kind of car do you drive? -- usually in knee cases - if left knee is injured bad, it is bad if soldier drives standard transmission. Automatic is better. If right knee injured better if it has cruise control.

m. Do you go shopping at the mall? looking to see if soldier can stand and walk for long periods. If you go tell the board how far you can stand/walk, if you need to rest (benches).

n. Is your driver's license restricted? If condition is severe the Army or state may restrict, or revoke, driving privileges. Any restriction relating to impairment or handicapped license plates

o. Do you get along with superiors? Board may be looking for ulterior motives-- injury not that severe and board thinks that pressure from superiors is reason the soldier wants to get out. Answer - yes or no honestly - if no, explain. Board does not like to hear that superiors are "out to get" a soldier.

p. If condition is old, when did you become unfit?

q. What is your VA rating? If the soldier has one, use it to compare the severity - usually only applies to TDRL or Reservists or National Guard.

2. Other Tips

a. Do not lie, the board will usually catch it.

b. Say good morning/afternoon Sir when the board members are introduced.

c. Look the board members in the eye when answering questions.

d. Do not yell at a board member. Ask for a break first.

e. If you need to, you may stand up during the hearing.

Developed by Fourth Infantry Division (Mechanized) Legal Assistance Staff

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Physician's Corner

This section discusses the MEB impact on readiness and offers a NARSUM Tool

- ***MEB Impact on Readiness***
- ***Performance***
- ***MEB NARSUM Tool***

MEB Impact on Readiness

From the time a soldier receives a P-3 or P-4 profile, he or she is virtually lost to the unit. The unit, under great pressure to maintain a high operational and personnel readiness posture, can ill afford to have soldiers spending excessive time seeking medical treatment. Until the soldier is processed (MEB through the remaining PDES phases) and receives orders to terminate service or return to duty, the unit can not fill his or her position, thereby degrading unit readiness. This is precisely the point at which the physician can contribute to soldier health and unit readiness.

Performance

The MEB process at MAMC is a team effort. Several persons are involved with every case and therefore have an opportunity to improve overall performance. Data collected from the Fort Lewis PEB, as well as a graduate thesis on the subject of MEB processing time, indicate MAMC MEB cases average 157 days from time of referral to a MEB until the case is delivered to the PEB. The greatest amount of time is consumed in the initial phase of the MEB - treatment and diagnosis. The USAPDA reports that MAMC has a 14% case return rate from the PEB due to incomplete medical documentation. These errors can be eliminated in two basic ways.

The first is that physicians can use the MEB worksheet developed by LTCs Johnstone and Hansen (MAMC Orthopedics and Ophthalmology) to complete the MEB requirements.

Click the flag to open the document in a separate window 

The form basically includes all required information and eliminates the opportunity for missing information. It is recommended as an aid - not a total fix. Physicians need to recognize disqualifying injuries or circumstances, refer soldiers promptly to a MEB, and ensure accuracy and completeness in their medical reports.

The second method for eliminating errors with MEB packets is to communicate with the PEBLO involved. PEBLOs in turn are responsible for communicating with physicians to improve the process as well as review packets for completeness and accuracy before submitting them to the PEB.

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